HOSPITAL MANAGEMENT

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HOSPITAL MANAGEMENT:

BEING THE

AUTHORISED REPORT

OF A

CONFERENCE

ON THE

ADMINISTRATION OF HOSPITALS

Held under the auspices and management of the Social Science Association on the 3rd and 4th July 1883.

EDITED BY

J. L. CLIFFORD-SMITH,

Secretary of the Association.

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1883.

PREFACE.

THE attention of the Council of the Social Science Association has on several occasions been drawn to the subject of hospital management and administration. At the Dublin meeting, in 1881, they adopted as one of the questions for special discussion in the Health Department the following:—"Is it desirable that hospitals should be placed under State supervision?" and on this question, by invitation of the Council, a paper was contributed by Mr. Henry C. Burdett.* At the close of an interesting discussion a resolution was unanimously passed recommending the Council to petition the Crown in favour of the appointment of a Royal Commission of Inquiry. In pursuance of this resolution the Council subsequently appointed a special committee to inquire for themselves into the whole subject, those who served on that committee having included:—Sir T. Fowell Buxton, Bart.; Mr. J. H. Buxton; Mr. Henry C. Burdett; Dr. Alfred Carpenter; Mr. William Clode; Mr. H. H. Collins; Dr. Farquharson, M.P.; Dr. Grigg; Dr. Habershon; Mr. Rowland Hamilton; Mr. Timothy Holmes, F.R.C.S.; Colonel Keatinge, V.C.; Mr. C. Macnamara, F.R.C.S.; Mr. F. G. P. Neison; Mr. J. S. Phené, LL.D., F.S.A.; Mr. Francis S. Powell; Sir William Robinson; Sir (then Mr.) Edwin Saunders, F.R.C.S.; and Dr. Gilbart-Smith. The labours of this committee, under the

* See *Transactions*, 1881, p. 498.

presidency of Mr. Powell, extended over a period of some months, and in order, furthermore, to arrive at a more general expression of opinion, an afternoon meeting was held in the month of December, when the subject, ably introduced in a paper by Mr. Timothy Holmes, Surgeon to St. George's Hospital,* was thoroughly discussed in all its bearings. The following resolutions were also unanimously adopted by the meeting, which was largely and influentially attended :—

That the Council of the Social Science Association be recommended to present a memorial to Government praying that Her Majesty will issue a Royal Commission to inquire into the administration of all hospitals ; and, further, that the Home Secretary be asked to receive a deputation from the Council of the Association to urge the prayer of such memorial.

That this meeting suggests to the Council the expediency of recommending that the various hospitals of London should combine to organise a common council of representatives of each institution for the purpose of considering the best means for managing their respective charities.

The committee, after mature deliberation, came to the conclusion that the recommendation conveyed in the first resolution would be more efficient if it were in the first place confined to metropolitan hospitals instead of being extended to "all hospitals," and on this basis they prepared for the consideration of the Council an elaborate memorial, accompanied by an "explanatory memorandum." These were unanimously adopted by the Council in March, 1882, and the Home Secretary was requested to receive a deputation to urge the prayer of the memorial, which set forth that, whilst anxious to disavow the

* See *Sessional Proceedings*, Vol. XV., p. 35.

intention of adopting any recommendation in favour of compulsory Government control or management of voluntary hospitals, the memorialists were not less desirous of expressing their opinion that a favourable time had come for the institution of a full and impartial inquiry into the accommodation afforded by, and into the present system of the management and administration of, the metropolitan hospitals and the other institutions for the medical treatment of the sick. The memorialists therefore prayed that Her Majesty might be pleased to issue a Royal Commission to ascertain the needs of the metropolis, with a view to obtain reliable data upon which to base such reforms as might be necessary, and to make such recommendations as might appear desirable.* In consequence of the state of public business the Home Secretary expressed a wish to have the views of the Association conveyed to him in writing instead of by deputation. Our papers were therefore, in the month of May, 1882, sent in to the Home Office, and the Council were in due time favoured with an official acknowledgment of their receipt.

The matter was not, however, allowed to rest at this point. The subject was again put down for discussion at the next Congress of the Association, which took place at Nottingham in September, 1882; and the question was on that occasion formulated for special discussion in these terms :—"What reforms are desirable in the administration of hospitals?" Dr. Gilbart-Smith, Assistant Physician to the London Hospital, was invited to prepare the

* The full text of the memorial and memorandum will be found in Appendix B.

paper, and he exhaustively and ably placed before the Association the various arguments brought forward by hospital reformers. The discussion which followed the reading of this paper resulted in the passing of the subjoined resolution :—

> That this Department, deeply convinced of the necessity of reform in the administration of metropolitan hospitals and other institutions for the medical treatment of the sick, requests the Council to continue their exertions to obtain the appointment of a Royal Commission, with a view to obtain reliable data upon which reforms should be based, and to make such recommendations as may appear desirable.

The resolution was reported to the Council in November last, and the standing committee of the Health Department, with power to add to their number, were subsequently empowered to convene a Conference of hospital managers and others interested in the subject, with a view to obtain in a practical manner an indication of the views held by hospital managers themselves. For this purpose invitations were issued to nearly every hospital, dispensary, and convalescent institution in the Kingdom, and communications were specially made with the chairmen of several hospitals in regard to various parts of the programme. The Conference, which was held in the Hall of the Society of Arts, under the presidency of Sir T. Fowell Buxton, Bart., on the first day, and of Mr. Francis S. Powell on the second, took place on the 3rd and 4th July, and was a success in every way. The papers, of which there were fourteen on the various divisions of the subject as set forth in the programme, were all good; the discussions were well sustained; and the order of proceedings came appropriately to an end with a unanimous call for a Royal Commission

of Inquiry, and the appointment of a committee of hospital managers to consider what steps should be taken to secure combined action among hospitals, and to decide as to future Conferences. This committee has already held its first sitting, and has taken steps for materially adding to its numbers. A sub-committee has also been appointed to prepare a draft programme for consideration in October next by the enlarged committee.

J. L. CLIFFORD-SMITH.

1, Adam Street, Adelphi, W.C.
September, 1883.

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CONFERENCE

ON THE

ADMINISTRATION OF HOSPITALS,

JULY 3RD & 4TH, 1883.

Among those who were present were the following :—

The Right Hon. the Earl of Cork and Orrery (*St. George's Hospital*); Viscount Powerscourt, K.P.; Sir Thomas Fowell Buxton, Bart (*London Hospital*); Sir Thomas Dyke Acland Bart, M.P. (*Guy's Hospital*); Mr. James Cropper, M.P; Dr. Farquharson, M.P.; Mr. Albert Pell, M.P.; Sir Charles E. Trevelyan, Bart., K.C.B.; Sir William Wheelhouse, Q.C.; Mr. George Abbott; Dr. H. W. D. Acland, D.C.L., F.R.S.; Dr. John Alexander (*Western Infirmary, Glasgow*); Mr. William Allam; Mr. J. S. Baily; Mr. Thomas Blair (*General Infirmary, Leeds*); Captain Blount, R.N. (*Victoria Hospital, Chelsea*); Mr. J. S. Blyth (*Royal Free Hospital*); Mr. William Bousfield (*Metropolitan Provident Dispensaries' Association*); Dr. W. A. Brailey (*Guy's Hospital*); Dr. J. S. Bristowe, F.R.S. (*St. Thomas's Hospital*); Mr. H. Cadbury Brown; Rev. Thomas Birkett (*Hospital, Weston-Super-Mare*); Mr. W. T. Bunn (*Provident Medical Association*); Mr. Henry C. Burdett (*Seamen's Hospital, Greenwich, and Home Hospitals Association*); Mr. J. H. Buxton (*London Hospital*); Mr. E. Burn Callander (*London Fever Hospital*); Mr. F. C. Carr Gomm; Mr. M. D. Chalmers (*London Fever Hospital*); Rev. Canon Erskine Clarke, M.A. (*Bolingbroke House Pay Hospital*); Mr. J. L. Shaw Clarke; Dr. T. Fairlie Clarke; Mr. H. H. Collins; Mr. G. A. Cross (*Homœopathic Hospital, Great Ormond Street*); Mr. A. P. Curtis; Mr. Ernest Derenth (*City Orthopædic Hospital and Provident Dispensaries, Pimlico*); General Erskine (*Seamen's Hospital*); Mr. W. T. Evans (*Seamen's Hospital*); Mr. John Fisher (*Metropolitan Asylums Board*); Hon. Dudley F. Fortescue; Mr. S. D. Fuller; Captain Douglas Galton, C.B., D.C.L., F.R.S., (*University College Hospital*); Mr. Daniel C. Gilman (*President of the Johns Hopkins University, Baltimore, U.S.A., and late President of the American Social Science Association*); Miss Annie Goff (*East London Hospital*); Mr. H. Howgrave Graham (*Hospital for Epilepsy and Paralysis*); Mr. Leigh Gregson (*Southern Hospital, Liverpool*); Mr. J. J. Gurney (*Infirmary, Newcastle-on-Tyne*); Mr. Rowland Hamilton;

Mr. H. Nelson Hardy (*late Surgeon City of London and East London Dispensary*); Mr. A. G. Henriques (*the London Hospital*); Mrs. Sarah Heckford (*East London Hospital*); Mr. John Hilton (*London Temperance Hospital*); Lieutenant-Colonel Holloway; Mr. Timothy Holmes, F.R.C.S. (*St. George's Hospital*); Mr. E. R. Hordley; Mr. H. W. Hubbard, L.R.C.P. (*Guy's Hospital*); Mr. Richard James; Mr. Hugh Jamieson; Rev. C. A. Jones (*Westminster Hospital*); Colonel R. H. Keatinge, V.C.; Dr. Evory Kennedy; Mr. R. G. Kesten (*Royal Hospital for Children and Women*); Mr. F. W. Kirby; Mr. G. W. Lane (*President of the Chamber of Commerce, New York, President of the Presbyterian Hospital, New York, and a Manager of the Sailors' Home, Snug Harbour, New York*; Mr. G. B. Lloyd (*General Hospital, Birmingham*); Mr. C. S. Loch (*Charity Organization Society*); Mr. A. L. Lundy; Dr. W. Mackenzie; Mr. C. Macnamara, F.R.C.S. (*Westminster Hospital*); Mr. H. M. Macpherson (*St. George's Hospital*); Mr. James Marshall; Mr. Benjamin Maskell (*Royal Orthopædic Hospital*); Mr. J. Mattheson; Mr. Henry Maudslay; Mr. W. V. Mercier (*St. John's Hospital, Leicester Square*); Mr. P. Michelli (*St. Mary's Hospital*); Mr. F. D. Mocatta; Mr. Joseph Moore (*Chairman, Seamen's Hospital*); Mr. Ernest Morgan (*Ventnor Hospital for Consumption*); Mr. H. M. Murray (*Charing Cross Hospital*; Miss Amy Nicolson; Mr. H. N. Nixon (*University College Hospital*); Mr. H. W. Page, F.R.C.S. (*St. Mary's Hospital*); Mr. Robert Treat Paine (*President of the Charity Organization Society, Boston, U.S.A.*); Dr. Philipson (*Infirmary, Newcastle-on-Tyne*); Mr. J. F. Pink (*Dental Hospital, Leicester Square*); Mr. Francis S. Powell; Mr. S. M. Quennell (*Westminster Hospital*); Mr. C. J. Radley (*Metropolitan Provident Medical Association*); Colonel C. Ratcliff; Mr. B. Burford Rawlings (*National Hospital for the Paralized and Epileptic*); Mr. Arthur Reade (*Charing Cross Hospital*); Mr. W. Rendle, F.R.C.S.; Mr. R. R. Ridmayne (*Infirmary, Newcastle-on-Tyne*); Mr. Charles Roberts; Mr. Thomas Ryan (*Queen Charlotte's Hospital*); Mr. R. Salmond (*British Home for Incurables*); Mr. Leveson E. Scarth (*Convalescent Committee of the Charity Organization Society*); Mr. John Scott; Dr. Edward Seaton (*Nottingham*); Mr. William Shaen; Captain Sheffield (*London Temperance Hospital*); Dr. Gilbart-Smith (*London Hospital*); Mr. J. Raymond Smith; Mr. Arthur Sperling; Mr. T. H. Staples; Mr. C. T. Stewart (*London Fever Hospital*); Dr. O. Sturges (*Westminster Hospital*); Mr. A. Thorne; Miss M. Sutcliffe (*Radcliffe Infirmary, Oxford*); Dr. E. T. Tibbits (*Infirmary, Bradford*); Miss Tillard; Mr. Alfred Waddilove, D.C.L.; Mr. Ashton Warner (*East London Hospital*); Mr. Andrew Wentzell; Mr. L. de Wette; Mr. Joseph White, F.R.C.S (*General Hospital, Nottingham*); and Mr. J. S. Wood (*Bolingbroke House Pay Hospital, and Chelsea Hospital for Women*).

FIRST DAY.

JULY 3RD.

The President, Sir Thomas Fowell Buxton, Bart., who took the chair at 11 a.m., in opening the proceedings, said:—

It is very clear what are the reasons that have led to the wish that a Conference should be held to deal with the various questions which cluster around the hospital system not of the metropolis only, but of the whole kingdom. During the last ten years much more active thought and criticism have been brought to bear on the hospital system than formerly. Perhaps before there was as much personal sacrifice, as much readiness to give, to devote time and attention to the administration of hospitals singly; but each was taken to stand by itself: men were loyal to their own institution; they devoted time, attention, and labour to it. Previously, perhaps little attention was given to the mass of necessity which had to be relieved, whilst a great deal was given to the particular machinery for relieving the necessities of a particular area. Within the last ten years there has been a greater readiness to look upon the necessity on the one side and on the means of meeting it on the other, with this result that a great deal of fault has been found, a great deal has been said to show that what has to be done is very far from being done properly. Men have given attention to the necessities of large areas in which they found an insufficiency of means for the relief of the sickness of the districts, while for others of a similar character there has been an ample supply. These facts have given rise to a good deal of thought and discussion, accompanied sometimes by a certain degree of heat, which is a healthy symptom of an active desire to solve the problems suggested by the existing condition of things. Among the reasons which have led to the increased consideration of the whole question there are two or three which stand out prominently. Foremost among them no doubt has been the growing pressure on the funds. Two causes perhaps have been producing this result. One is that there has been an increase in hospital expenditure. Taking hospitals and infirmaries all round, and estimating the expense per bed or per patient, we shall find that there has been an increase

of outlay, owing, perhaps, to the higher standards which it has been thought right to adopt in regard to the necessaries, comforts, and luxuries supplied to patients. At the same time I fear that in the case of many hospitals there has been a falling off in the supply of funds. I do not believe the public is less willing to give than it has been in times gone by. Probably the amount given from year to year is fully as large as, or it may be considerably greater than, it used to be. One fact which has helped to diminish the means that are forthcoming for any particular object of charity is that the number of objects has so much increased, and there are so many new channels in which subscriptions flow. There are increased demands from our foreign possessions, and there is a greater variety of demands at home, which have very much made up for certain spheres in which there has been a falling off. For instance, subscriptions have been relieved to the extent that the cost of elementary education has been thrown upon the rates; but on the other hand there are from year to year a greater number of demands upon those who are willing and able to aid their fellow creatures. In the matter of medical relief there have been increasing demands; and more has been required for convalescent homes. However it is brought about, a number of hospitals, and of the larger hospitals especially, have experienced greater difficulty in raising the funds they required. That has been perhaps the chief reason why those who are connected with the administration of hospitals have been led to consider the subject as a whole, and to inquire how in the future those funds are to be supplied. That has led to the consideration of the whole system and to inquiries as to the best mode in which hospitals can be supplied and governed. The fact has thus been brought home to the minds of men that the system itself is incomplete. In the north and east of London they see large areas and vast populations altogether unsupplied, or poorly supplied, with the medical relief which is given in hospitals, while in other parts, as for instance within a short radius of this hall, will be found an enormous proportion of beds in a number of hospitals. The hospital supply is found to be badly distributed; there are places where there is an excess of them, and there are huge areas where they are altogether wanting. My own observation in that respect is that there is a great want of organisation; and there is a great lack of accommodation in districts which demand and require it. This state of things has led men to ask, "Ought there not to be some

central body to determine in what way the demand shall be met? and is it not possible to set up a central body which shall determine not only where hospitals shall be placed, but how they shall be governed?" These questions have been passing in the minds of men with very great force during the last few years. The idea of holding a Conference occurred to some members of hospital committees and other committees, and five or six years ago Mr. Burdett made a suggestion of that kind in *The Times* which attracted considerable attention. In 1879 a few gentlemen connected with different hospital committees met at my house to consider some of these questions, and they came to the conclusion that it was expedient that there should be a Royal Commission to inquire and report upon the whole question of the supply of hospital relief to the population of London. Since then the same questions have been discussed at meetings of the Social Science Association. A further step was taken by those who especially represented medical departments of the hospitals, and the medical gentlemen met together in a representative assembly to discuss these questions. These facts show that the subject has excited an increasing interest during the last few years; and no doubt it will be elucidated and advanced by the papers and the discussion at this Conference.

Mr. Francis S. Powell (a past President of the Health Department of the Association) in a few words traced the connection between this meeting and the Social Science Association. The administration of hospitals had been one of the subjects discussed from time to time in the Health Department. At the Dublin Congress, in 1881, a paper was read by Mr. Burdett, and subsequently at the rooms of the Association in London another paper, by Mr. Timothy Holmes, was read, and was followed by an important discussion. At the last Congress of the Association, held at Nottingham in 1882, a further paper, dealing very exhaustively with the whole subject, was contributed by Dr. Gilbart-Smith. It was felt that the question could not be allowed to remain in the position it occupied, and that all these papers and discussions ought to lead to action. A committee was constituted, of which he had the honour of being chairman, to consider whether some further steps should not be taken with a view to a complete investigation of the whole subject; and the committee was greatly assisted by some members of the Association and other experts who had taken part in the discus-

sions. In 1882, a memorial of some length was prepared and submitted to the Home Secretary.* It contained certain facts which appeared to furnish sufficient ground for further investigarion by a Royal Commission into the administration of London hospitals. The attention of the committee was directed to London alone, because it was then thought that a Royal Commission would have sufficient employment in London without extending its inquiries to the provinces. The Home Secretary declined to receive a deputation in support of the prayer of the memorial. He promised, however, to consider the documents that were submitted to him, and the result of that consideration was a negative reply to the prayer of the memorialists. Therefore they stood with the refusal before them of the petition they had presented for a Royal Commission. That which a Royal Commission was not permitted to do, he hoped that friendly efforts might effect. He trusted the result of their deliberations might be an interchange of opinions, that the information which was possessed would be generally diffused, and that many reforms might be made, some of them apparently small in themselves, but still highly important items in a great common result. There was not in these proceedings any feeling of hostility towards any institution. Hospitals were beneficent institutions, for the good of the community, and all present would feel that it was their primary duty to discuss the matter in a friendly spirit. The discussions would be of little use unless they were of a searching character, but he trusted they would be characterised by a friendly tone and with a regard to the good of the great community for the benefit of which they were privileged to labour.

The following Papers were then read :—

I.—*Hospital Administration. The Governors and the Management of Hospitals. The Selection and Appointment of Committee-men.* *By* B. Burford Rawlings, *Secretary, National Hospital for the Paralyzed and Epileptic.*

Before submitting a few observations under the text set forth, I must beg leave to make it plain that they are but the expressions of individual opinion.

* See Appendix B.

The main proposition sought to be established is the desirability of obtaining for hospitals a management stable in character and impressed with a sense of responsibility in a degree not as yet generally attained to. The large majority of those intimately acquainted with the working of governing bodies doubtless will agree that nothing helps more to unsatisfactory results than the action of an ever varying combination of minds whose attention is only momentarily fixed upon a given subject, and whose opinions are formed upon a an imperfect comprehension of its details.

When, with a view to a remedy, we enter upon a consideration of such shortcomings in hospital management as are shown to have an actual existence, it is perhaps well that no portion of the hospital body should escape the process of examination. Yet the particular part of the subject which has fallen to my share appears a delicate one to handle, and an attempt to penetrate too deeply might be fraught with peril to the whole organism. The governors constitute the heart of the hospital. Its warmth, its life-blood spring from them; it is the child of their benevolence and the creature of their bounty. What then should be the position of the governors in regard to the management? Virtually they are the proprietors of the hospital, for they have founded it and they maintain it. That they have the right to control the management cannot be denied, but is their interference likely to be beneficial?

In the position reached by this question we have an early indication of the uselessness of attempting to engraft logical conclusions upon a purely sentimental system. Hospitals are private associations which have voluntarily assumed and are expected to perform public duties. Their supporters are under no obligation to repair the negligence of the State except such as a benevolent instinct imposes, nor do the institutions enjoy those immunities and privileges which naturally occur to the mind as a fitting recompense for the value of the work they perform. Their independence is thus complete. They severally frame their own constitutions, enacting such rules as seem to them good, and the custom is to confer upon contributors certain nominal rights including a participation in the management. The donation of a stipulated sum of money constitutes the donor a "governor" for life. This is no attempt to ask for any but a monetary qualification.

Looking at the subject in the light of recent contentions, the two inquiries which arise are: — Does a donor to a

hospital incur an obligation in regard to the institution he supports, and is it desirable and profitable that this obligation should be recognized? Undoubtedly the word governor conveys to the mind the idea of governing. It is a suggestive and euphonious title, pleasant to assume and not altogether without a marketable value to the institution. The reason of its application to donors may be guessed at, although its origin is hidden in the gloom of an impecunious antiquity. But if it be merely the inappropriateness of the title which jars on susceptible ears, there is little in the argument. No doubt it is a pity that things are not called by their right names; but with treasurers who keep no treasure, presidents who never preside, and consulting physicians and surgeons who are never consulted, is it not somewhat captious and ungrateful to find fault with governors that they do not govern, when they give freely of their gold, their sympathy and their prayers?

It appears quite an intelligible and praiseworthy position for a donor to assume when he says :—"I bestow upon the hospital my money and my best wishes, but I have neither the time, nor," it may be, "the health, nor the aptitude for taking part in the management." Is not this much more reasonable than that he should come forward and say—"I have paid my money and now I am here to claim my right to have a hand in directing your affairs." What if only a few of the hundreds of governors every hospital possesses assumed this attitude? Would it tend to harmony—efficiency—discipline—to any good thing? It seems difficult to imagine proceedings better calculated to bring about anarchy and chaos. Yet so wide has been the departure from rules of prudence and wisdom, that some hospitals exist under the government of what are called "open" committees—that is committees at which everyone who has contributed a certain number of guineas has a right to attend, to take part in discussion, and to record his vote. It is a testimony to the good sense and wise forbearance of donors that not many records are to be found of an exercise of this preposterous "privilege."

Of course, a donor may and should show an intelligent interest in the concerns of a hospital he helps to maintain, but any attempt to fix upon him an obligation, capable of being very unequally interpreted, is to be opposed, if only for the obvious reason that the quality of the interference is not ascertained and assured. It might be more fairly assumed that a contributor will exercise ordinary care in his alms-

giving, so as not to invest a dubious cause with the recommendation of his support, but even in regard to this, he might not unreasonably plead that the simple fact of an institution being allowed to appeal for subscriptions should be at least *primâ facie* evidence of its respectability.

Again, any checks and hindrances placed in the way of giving, would most certainly deprive hospitals of much of their income. People who argue for giving by rule and method must have a very imperfect knowledge of human nature. Some are donors because they must be—it is demanded by their position or by circumstances; others, it may be admitted, give because they feel that giving is a duty. But the great army of givers is not recruited from these classes. Their alms are the tribute pity renders to suffering. The compassion may be deep and enduring, but the indications of it are necessarily intermittent and impulsive. They are drawn forth by contact with particular occasions. Therefore any interposition between the impulse, and the deed which springs from it, is to be deprecated. If you induce hesitation in an intending donor, you will have done much towards diminishing his gift, or losing it altogether.

Then there is the charge upon a donor's conscience which the existence of any such obligation would imply. Once yet firmly established, an instruction to contributors that they are to be held morally responsible for the management of the hospitals they assist, and the legend "supported by voluntary contributions" will darken and fade out.

Further, we have only to consider the constitution of the body of governors of any hospital to be convinced of the impracticability of requiring their assistance in the management. What of minors and invalids, of the aged and the busy? What of the great array of donors whose names are to be found not in one list, or two, but a score? Nothing is more remarkable about a donor than his pluri-presence. His sympathies may comprehend not only many hospitals, but a variety of other objects. Is he to be held accountable everywhere? The very essence of public charity is its representative character.

Finally, to what purpose should we urge an obligation and responsibility there is no way of enforcing—which it would be fatal to enforce? The re-election of a committee may be refused; an officer may be dismissed—but what action can be taken against the contributors?

Let us accept what they give as a free offering to charity

and be grateful. To insist upon their obligations appears as ungracious as it is inopportune. It would magnify the present financial difficulties to a crisis, and, in regard to management, it could only aggravate the impersonality and instability which are already its distinguishing features.

These considerations naturally lead to a contemplation of the "Selection and Appointment of Committee-men." The committee of management is the administrative government of a hospital; the so called governors are the constituency. It is an irreproachable custom to elect the committee from the governors and subscribers; it is equally fitting that the latter should choose their representatives.

Granting that, under existing conditions, government by committee cannot be superseded, the serious question is how to ensure to committees the highest standard of efficiency of which they are capable.

The practice at most hospitals is to have managing committees composed of a large number of members. One result of having a large committee is to diminish the sense of individual responsibility. Some members may attend very seldom; others at uncertain intervals, and the few who are always in their places may be at any time thwarted and outvoted by the contingent which will rally to decide some important question whose earlier discussion they may have taken no part in. The *personnel* of the sitting committee is therefore rarely the same, and of course its opinions are proportionately fluctuating and uncertain, and especially so at the most unseasonable times.

It may be urged that in a multitude of counsellors there is wisdom, but surely the acceptance of this involves the establishment of an antecedent proposition that the counsellors are at least attentive.

A great disadvantage under which the authorities of a charitable institution labour is born of the indigence it suffers, and in fairness it should be remembered that what they do is sometimes regulated less by their judgment of its merit than of its expediency. It will be a great day for hospital management when it can be persuaded to put confidence in the loyalty of the institution's best friends and to estimate at its real worth the support of those whose favours are only to be bought by concessions to their prejudices.

We should scarcely go wrong if we applied to hospitals those rules and methods which obtain in ordinary business undertakings. Would any man entrust the management of

his enterprises to a committee never likely to be constituted twice alike during the year?

Similarly it would be opposed to practical opinion that managers should be pluralists. We have seen that the sympathies of contributors, happily, are often cosmopolitan. In regard to committee-men, a concentrated attention is demanded, and surely a more useful work is to be performed by maintaining an uninterrupted and hence more intelligent part in the supervision of one undertaking, than in giving an occasional thought to the affairs of half-a-dozen.

The real difficulty is to procure this continuity of attention. The position of a committee-man is so purely honorary; his individuality is so lost in a multitude of colleagues; there is so little to fix his own personal obligation, that he may be well excused if his interest languishes. Assuming him to be in earnest, that interest would be increased as the number of his colleagues was lessened. Anything which makes the individual responsibility more conspicuous will exalt the efficiency of the whole body, while another benefit arising from diminution of numbers would be the attainment of unity in purpose and action to an extent impossible when the maintenance of any given resolution depends upon the acquiescence of a minority—or it may be a majority—of members who were not parties to its adoption.

A most important portion of the subject is the relation the governing committee should hold towards the medical staff and to what extent the staff should be represented upon it. Considering the nature of hospital work, and how hospitals, their committees and managers exist only to promote the labours of the profession, it is in the highest degree desirable that the managing body should possess the confidence and, consequentially, the loyalty and obedience of the staff. How are these to be obtained? If we judge by the contentions of some medical writers, nothing will be satisfactory but the eradication of lay authority. Upon the other hand lay controversalists may be easily led into rendering imperfect justice to the reasonable requirements of the medical interests.

It is certain that neither party is independent of the other. A hospital minus the confidence and good will of the faculty is really without a license to exist; while medical advocates have only to remember that it is laymen who supply the money to build and maintain, to comprehend the nature of the right acquired by their representatives.

Whatever may be urged in respect of purely scientific

considerations, the maintenance of the benevolent character of hospital work can only be secured by leaving the supreme authority to a non-professional body. The exercise of this authority should be inspired, of course, by a due appreciation of the two-fold character of the work to be performed, but with the physician in possession, as he must rightly be, of so powerful a position in respect of the selection of patients for in-treatment, it is impossible that any lay authority, however narrow and unintelligent its views, can place serious obstacles in the way of the legitimate requirements of science. The amplest opportunities should be afforded the staff to make known their opinions in all matters, and this not only in justice to the staff, but in the best interests of the hospital. At present a medical committee is usually a hybrid body; it might be advantageous that it should be composed of members chosen from the staff, without any admixture of laymen.

In regard to the governing committee, there are reasons why it appears undesirable that members of the active staff should be included in it, while there are others equally cogent for requiring that it should be adequately leavened with medical knowledge. A medical member, sitting at all boards as an assessor, would be a valuable acquisition. Probably physicians whose term of active service had expired would be suited to this position, and the appointment might be made by the votes of the governing body and medical committee combined. Or why should not the aid of the Royal Colleges of Physicians and Surgeons be invoked in a matter which must nearly concern them? They must possess the confidence of the profession at large. What if each college nominated one member for every hospital committee?

In some such way, medical interests ought to be safeguarded—in a committee, diminished in number they would certainly receive an ampler relative representation than at present, while the lay-managers would acquire one or more able colleagues competent to advise them authoritatively in matters where their own unaided judgment might be at fault, yet elevated above and unhampered by influences a member of the working staff might find it difficult to withstand.

Essaying to gather up such threads of argument as underlie these observations, I would submit that the first need is to eliminate from committees the elements of vacillation and unreality and to render them robust and stable. A model

committee might be constituted thus: a medical member; a legal member; a member with actual experience of executive management as an ex-treasurer or ex-house governor, and two or three men of business with special inclination for the work. Merely ornamental members ought to be rigidly excluded, and it would not be too much to ask of those who undertake the duties an explicit engagement to perform them. Vacancies should be filled with due regard to the place the retiring member has occupied, so as to maintain unimpaired the structural constitution of the committee. Under such conditions there should be no dearth of aspirants, and to be a member of the governing body of an important hospital ought to confer an honourable distinction.

Looking at the many good friends hospitals possess, at the abundance, if a not uncommon phrase may be used, of the raw material, it ought not to be difficult to obtain a committee of members individually pledged to all that may be reasonably required at their hands. Happily, most hospitals have succeeded in gathering about them some who are not supine and indifferent. The history of many will show how much may be accomplished by a few zealous workers. Let us render homage to the earnestness of efforts carried on, not seldom, under circumstances well calculated to weary and discourage.

Efficiency will be promoted and sustained by an ampler sense of personal responsibility, and this in its turn will be secured by a concentration and fuller evidence of authority. We want such a process of evaporation set up by the application of more stringent conditions as will carry off the volatile elements and leave behind all that is essential. A hospital needs the niceties of personal government stimulated and controlled by a sense of public accountability. There is probably no work in which individual ability is so mercilessly stifled as in the administration of a hospital. The trammels of tradition, the irrationality of such precepts as spring from a history of indigence, and the inertia of minds to whose instincts enthusiasm is criminal, these are difficulties to be overcome. A small highly organised committee of the kind suggested, constantly equipped for service, containing in itself the sources of such knowledge and experience as are needful, its members mutually advising and bound together by an ardent solicitude for the welfare and utility of the institution they serve, with a chief officer who should be their eyes and hands, working with them and under them, would prove more effective than all the elaborations of

councils and courts ingenuity has devised as if to obscure and smother the faculties which need free scope, bracing air, and a measure of sunshine to ensure their fairest development.

II.—*Hospital Administration :—The best Forms of Executive Government, i.e., by Treasurer, House Governor, or Medical Superintendent. Medical Representation in the Management.* *By* J. S. BRISTOWE, M.D., F.R.S.

The object which I set before myself when I undertook to read a brief paper at the present Conference was, as I believe I originally explained to the secretary, not to enter upon an exhaustive discussion upon "the best forms of executive government of hospitals," and of the question of "medical representation in their management," but simply to place before the Conference our experience at St. Thomas's of two varieties of government (of which the first prevailed down to six years ago, and of which the latter has been in operation ever since), and to deduce from our experience the lessons which it seems to teach.

The management of St. Thomas's Hospital (like that of the other Royal Hospitals) resides in governors, of whom the Aldermen of the City of London, and a certain number of the deputies are governors *ex-officio*, and the others are elected as a general rule only after having given a benefaction to the hospital of £50 at the least. They number, I believe, between two and three hundred.

The office-holders among the governors are the president, whose duties have always, I believe, been nominal; the treasurer, who is the actual head of the institution, who is provided with a residence, who has the control over all the other officers and servants in every department, and who also (as his name signifies) manages the finances of the hospital; a grand committee of thirty governors (besides the president and treasurer); and a sub-committee of almoners, consisting of four members of the grand committee. There are other committees having special duties, to which I need not refer.

The almoners meet as a general rule once a week, to advise and assist the treasurer in the management of the hospital.

The grand committee is generally held once a month and

regulates the affairs of the hospital in general, subject to the approbation of the general court.

The general court of governors is held regularly four times a year, but may, under certain conditions, be called together more frequently.

It would be difficult for anyone who is not a working governor to explain exactly what are the respective duties of these several bodies, nor is it necessary for my purpose.

It is sufficient for me to say that down to October, 1877, the lay control of the hospital lay practically in the hands of the treasurer. He was the elected head of the institution, he resided on the spot, the grand committee and the sub-committee of almoners were to a large extent his nominees, and as a general rule fell in with his wishes and endorsed his recommendations; and hence he possessed almost despotic power. I do not mean to say that, if it came to an actual conflict of opinion, the treasurer could not be beaten by the sub-committee of almoners, his sub-committee of almoners could not be beaten by the grand committee, the grand committee could not be beaten by the governors assembled in general court, and hence to deny that a majority of governors could, on occasion, carry their own views in opposition to the treasurer. In fact I have known this to happen. Nor do I mean to say that the treasurer did not honestly consult with his committee and sub-committee, and that he never deferred his opinion to theirs. Indeed I know that the treasurers of my time did act thus. Nevertheless the treasurer was practically a despot, and it rarely happened that whatever he had determined on was not carried into effect.

It may be assumed that during all this period treasurers were anxious to obtain the opinions and the assistance of the medical and surgical staff in all matters relating to the management of the patients, and in all matters in fact relating to the hospital, excepting the management of its property and its finances, the election of governors, the bestowal of patronage, and other matters with which the medical staff had obviously no concern. And I have no reason to doubt that treasurers did, as a rule, endeavour in some way or other to obtain this assistance. But how was it done? The staff as such had no *locus standi* in the hospital councils. I know that for many years the apothecary of the hospital, a man of great ability and strong opinions, had far greater influence over the treasurer in matters medical than the whole of the medical and surgical staff. And I know also that for many

years the treasurer was largely influenced by a retired member of the staff, who made himself a governor, but who had been a failure as a physician, a failure as a teacher, at enmity with his colleagues, and who was a crotchety and ignorant adviser. Generally, also, if the advice of the staff was sought directly, it was obtained through the medium of a lengthened epistolary correspondence, or the members of the staff were examined one by one apart, or some one member who had acquired influence was alone consulted. I do not know that I can convey a better notion of what the relations of the medical staff to the governors were in those days than by quoting an extract from an introductory address which I delivered on the 1st of October, 1862, at the time when St. Thomas's had just taken up its temporary abode in the Surrey Gardens, and its ultimate destination was as yet unknown. We had reason to believe that the treasurer at that time wished to remove it into the country. The medical staff had not been consulted formally or informally on this matter; and I seized the opportunity which the delivery of my address afforded me, not only to tell the treasurer, who was in the chair, my own opinion with respect to what the position and character of the future hospital should be, but to express my views with respect to the unsatisfactory relations which existed between the governors and the staff. My remarks were as follows:—

"The future of the hospital is, at the present time, and from a broader point of view than that merely of the medical school, the most serious and momentous question with which the governors have to deal; it is a question to which everyone connected with the institution has probably devoted at least some thought, and on which he has formed some kind of opinion; it is a question too, as it seems to me, in reference to which it is scarcely possible that selfish or personal considerations can actuate, in the adoption of views, or in the expression of them, any body of men (I do not say individuals), whether they be the governors on the one hand, or the medical officers on the other, whether they be delegated by the public to act as their trustees, or whether they be appointed by the governors to carry out the objects of the charity; and yet, unfortunately, it is a question on which, between those who should have acted in concert, differences of opinion have arisen; and, I fear, not differences of opinion only. It is a fact, which it would be mere affectation to ignore, that not merely on the present

occasion, but for some years back at least, there has not been, between the medical officers and the governors, that cordiality which there ought to be, and which is so conducive to the harmonious and efficient working of an institution of this kind. I am myself less surprised that differences should exist between them, than that there should be cordial co-operation. When the governors have tried to obtain the opinions of the medical men on points of importance, and have seemed to obtain from them opinions at variance with one another, or opinions which have been subsequently repudiated, it is not very strange that the governors should come to regard those, whom they assume to have given them, as capricious and impracticable. When, on the other hand, men have devoted, for years, their best energies to the practical duties of a hospital, and have consequently been led to form strong opinions on questions of importance, upon which governors are called to decide, it cannot be cause for surprise that their trust in the governors should be shaken, when they find their opinions at one time ignored, at another time misunderstood and misapplied. The truth is that the relationship between them is not of a nature to conduce to mutual confidence and appreciation. Individual governors and individual medical officers know one another, and sentiments of personal esteem and good-will exist between them. But the governors as a body, and the medical officers as a body, do *not* know one another. They are rarely brought into contact; and, even then, the manner of communication is seldom one that can lead to a very satisfactory result. Thus, on points about which it is absolutely necessary that there should be some interchange of opinions; at one time, a desultory epistolary correspondence takes place fruitlessly, where five minutes' conversation would have led to a clear understanding; at another time, a member of the staff, it may be not delegated by his colleagues, is consulted, and opinions which may be peculiar to himself, and at variance probably with those of others, are assumed to represent the views of the medical officers. On rare occasions, a deputation is formed; and, I make bold to say (so far at least as we are concerned) that the results of this plan of communication are for the most part satisfactory."

"It is, I believe, in a permanent deputation, so to speak, that the true remedy for this state of affairs exists. To be more explicit, it is my entire conviction—a conviction

founded not only on a careful, and I believe impartial, consideration of the question, but also on the experience of the most successful and best of our subscription hospitals—that the true and efficient cure consists in the admission into the hospital councils, with liberty to join in discussion, either of the medical and surgical staff, or of delegates from that body. I am quite sure, that by an arrangement of this kind, fairly carried out, the governors would soon learn the real opinions of the medical officers, which they do not learn now; and that they would find themselves thereby materially aided in their deliberations, and in the performance of their duties. I am equally sure that feelings of mistrust would gradually cease, that apparently conflicting views would prove less irreconcileable than they seem to be, and that it would soon be discovered that all parties were equally striving, not to advance any personal object, but to enchance the efficiency, the prosperity and reputation of the hospital."

With the exception that, shortly afterwards, three of the members of the medical staff were chosen to confer with a committee of the governors as to the plan and construction of the hospital on the Thames Embankment, the relations between the medical staff and governors continued unchanged down to 1877.

In the latter part of that year, at the time of the appointment of our present treasurer, the following resolution was carried in the general court :—

"That this court approves of the proposed appointment of a house committee as recommended by the grand committee, and authorizes the grand committee to make the appointment accordingly, and that the house committee be empowered to make all needful regulations for its proceedings, and for the attendance upon it of the officers of the hospital, and that all members of the house committee shall be members of the grand committee."

"The house committee to consist of the treasurer, almoners, and six governors, two of whom should be gentlemen who have been physicians or surgeons of the hospital."

It was later determined that the house committee should meet generally once a week, and that one of the physicians, one of the surgeons, and the dean of the medical school should be invited to attend all its meetings, with all the privileges of the governor-members except that of being allowed to vote.

The house committee, as thus constituted, has existed ever since; and, I think, it is universally admitted with the best results. No unpleasant feelings, no difficulties of any importance have ever (since the appointment of the house committee) arisen between the governors and the medical staff. All kinds of questions relating to the management and arrangements of the hospital and school have been brought before this body from time to time, and as far as I can recollect have always been settled without undue expenditure of time, without loss of temper, and satisfactorily. I don't, of course, mean to say that always that which the staff desired has been carried out. But I do mean to say that whenever the governors have not shared our opinions, or have not seen their way to accede to our demands, there have been reasonable and sufficient grounds for their action. Further, owing to the cordial relations which have thus arisen between the governors and staff, various other matters, not strictly belonging to the house committee, which used to be sources of annoyance and discomfort, are now arranged and work satisfactorily. No persons ought to appreciate good nursing more than medical men; no persons, one would think, should take so great a pride in the education of nurses as the medical staff of a hospital. Now, I know that formerly it was supposed by some of the governors that there was antagonism between the medical staff and medical school on the one hand, and the nurses and the nursing-school on the other. That feeling has, I am sure, been wholly dissipated during the last six years; and the governors, I think, now universally recognise, what is a fact, that we take at least as great a pride in the goodness of our nursing and as enlightened an interest in the efficiency of our nursing-school as they do, and that so far from there being any antagonism, there is actually the greatest sympathy between us. And, consequently, although the house committee has no direct concern with the nursing staff, at any rate so far as concerns their appointment and dismissal, the physicians and surgeons have acquired quite as much influence over the nursing department as is either necessary or desirable. And, again, it has grown to be a regular custom to refer it to the medical staff to consider and report on the relative claims of candidates for medical and surgical posts in the hospital; a procedure which a few years ago would never have been dreamt of. We don't appoint, of course; nor does it follow

that the governors will select the candidates whom we recommend. But they seek and have the benefit of our collective advice ; and it is needless to say that that carries weight.

I will not go into further details as regards the advantages which have accrued from the establishment of our house committee. But, before concluding this brief paper, I will state shortly in what respects I think our plan better than some other plans that have been adopted with the object of giving medical staffs a share in the management of hospitals, and how I think it might be improved.

As regards the first point. It may be thought by some that it would be better to allow all the members of the staff to attend the house committee rather than only two or three. I am not of this opinion. If all the staff are permitted to attend there is the danger on the one hand that their attendance may become perfunctory, and, on the other hand, that the differences of opinion among them, probably in details, may reveal itself in discussion and weaken their collective influence. Besides, I have heard the complaint made by the governors of one hospital, where there is a committee thus constituted, that there is a tendency for the medical staff to sit upon the other members of the committee and to overbear them. I think the staff is best represented in such a committee by two or three representatives who are willing to undertake the regular and thorough performance of the duties required of them.

Again, there are many possibly who would think that the members of the medical staff on the committee should be allowed to vote. I think it far better that they should not ; and that they should obtain influence with the governors simply by the knowledge and good sense they bring to bear on the questions that come before the committee. If they cannot convince reasonable lay-men of the propriety of their views, so as to get them to vote for them, it is tolerably certain that the question under consideration has two sides to it, and either that it should not be carried in accordance with their wishes, or that it needs to be more fully considered and discussed. At any rate I can say from a tolerably long experience of hospital and other committees that I have never yet failed, when I was obviously right, to carry the committee sooner or later with me. I think if we had the power of voting, and especially if occasionally questions were carried by a narrow majority by means of our votes,

we should be apt to create discontent, and at any rate to lose influence and respect.

It will be seen therefore that I highly approve, on the whole, of the establishment of our house committee, of its constitution, and of the relations which the medical members of it hold to the rest. The only point in which I think it might be improved is the relation of the medical members to the staff and school. At present they are appointed by the treasurer; and it has acted so far satisfactorily because the selected members do, as a matter of fact, represent the staff fairly, and have their confidence. I think, however, it would be better that they should be elected annually by their own colleagues. And indeed I have no doubt that this will ultimately be the course pursued.

I should like finally to be allowed to say that nothing in this paper is intended to be disrespectful to former treasurers and governors of St. Thomas's Hospital. All whom I have known have been gentlemen who have been honestly anxious to do their duty; and disagreements between them and the staff, and undue friction between the several departments of the hospital, have been due more to the system of government which prevailed than to the faults of individuals. And further it seems to me that the satisfactory way in which things work now at St. Thomas's, and have worked for several years past, is due not so much to the exact mode in which the medical staff has been introduced into the management of the hospital, as to the fact that the medical staff are brought into direct and frequent relation with the governors, and are able to express their views on all matters of importance that concern them. And I am sure that if ever we lose the influence we now possess, it will be due either to our aiming to get more direct power than we are entitled to have, or to disagreements amongst ourselves, or to other injudicious actions of our own, which may be summed up in the expression "want of tact."

III.—*The Relation of the Hospital to the Medical School.* *By* T. Gilbart-Smith, M.A., M.D., *Assistant Physician to the London Hospital, Physician to the Royal Hospital for Diseases of the Chest.**

Of all the many aspects from which hospital administration may be viewed, none presents greater interest or more weighty responsibilities than that which reveals the relationship borne by the clinical hospitals to their medical schools, and the importance of this relationship is not lessened, nay, on the contrary, it is increased by the fact that it is for the most part ignored by hospital governors who fail to grasp their duty in the matter. In the remarks that I shall make I purpose dealing only with the metropolitan hospitals and their medical schools.

At the very outset of this question stands the fact that London mainly depends upon its clinical hospitals for the supply of the following needful and important items in its social economy:—

1. Skilled treatment, and that the best obtainable, for the sick and wounded committed to their care;

2. Men of high professional attainment to take their place as leaders of medical science and thought, and to occupy positions of eminence in the practice of medicine and surgery;

3. A medical education as efficient and thorough as the knowledge of the age permits; and

4. An accurate and scientific record of disease together with an enlightened application and use of the valuable clinical material contained therein.

These are the functions of our large metropolitan hospitals, and the public, acting in their own interests, will have jealously to guard and protect them from whatever would interfere with their successful progress.

On such an occasion as this it is surely needless for me to demonstrate how difficult if not impossible it would be for a hospital to fulfil these duties without the aid and co-operation of its medical school. For not only is the school needed in

* This Paper is inserted here, the place assigned to it in the programme, although the author was not able to be present to read it until the close of the second day's proceedings.—Ed.

order to provide, manipulate, and develop the mechanism required for the three latter functions—but it is also a necessary factor in the production and maintenance of the highest skill obtainable in the treatment of the sick, and the alleviation of suffering. Indeed, were it not for the attractions offered by the school, the wards of our hospitals would in vain seek for such medical and surgical skill as they now possess.

While I readily admit that the chief aim of a hospital is to heal the sick, yet intelligent minds will doubtlessly concede that in repairing injury, in controlling disease, and in averting death, a clinical hospital becomes charged with a duty whose importance is second to none, and whose effects cover an area of health and disease immeasurably greater than that occupied by the primary objects of its charity. This important and widespread duty is the weighty responsibility laid upon these hospitals to provide a practical and efficient medical education to all who may be attracted to their wards. The education of medical men, involving as it does matters of vital interest in every department of the State, public and private, should be as complete and practical as our knowledge permits, and the securing of fit and proper arrangements for the teaching of those sciences and arts to which every individual sooner or later must intrust the care of his health, is a subject of no trifling interest. It is therefore a necessity that the relationships existing between clinical hospitals and their medical schools should be such as are best calculated to promote this end.

If, untrammelled by existing systems and vested rights we were now occupied in devising a scheme that would furnish medical education with a mechanism in harmony with the requirements of the nineteenth century, we would I am confident, unhesitatingly and unanimously petition Her Majesty to charter a Royal College of Medicine where endowed by the State and smiled on by the people, the science of medicine would truly flourish. Within such an institution medical students, taught by professors eminent in their several departments, would be rendered proficient in anatomy, physiology, chemistry, and their allied sciences, and would thence be drafted off for clinical instruction in the art of medicine and surgery to the general and special hospitals, workhouse infirmaries, fever hospitals, and lunatic asylums which, under certain restrictions, would be affiliated to the Central College.

The time however for such action does not seem to have yet arrived, although it may not be far distant.

Meanwhile, seeing that we are met to discuss the relations of the hospitals to their schools as they now exist, we may well inquire whether any improvement may be effected in them.

In order to understand the position it is needful to glance at the hap-hazard origin of most of the metropolitan schools of medicine. In a paper read at the Nottingham Congress, at the request of the Council of the Association, I shewed that, resulting from private enterprise on the part of the physicians and surgeons of by-gone days these schools might, with accuracy, be described as the joint stock properties of the various staffs and lecturers. And I then explained their formation as follows:—A reference to official documents will prove that the physicians and surgeons holding hospital appointments are deputed to treat the sick; they are not appointed to teach their art. However, in proportion as they well fulfil their duty, they acquire a certain knowledge and skill in the treatment of disease. Now, inasmuch as the hospitals do not adequately, if at all, remunerate them for their services, and as by the very nature of those services they are for many years debarred from gaining suitable professional incomes, they have associated themselves together as joint owners of a scheme in which they impart the commodity they possess, viz., the above mentioned knowledge and skill. Moreover, in imparting these, they benefit the institution in a two-fold manner, for, by attracting the services of house physicians, house surgeons, clinical clerks, dressers, and others, they furnish the sick and wounded with gratuitous aid that would be difficult and costly to obtain; and, by the teaching of their art in the school, they render themselves more skilful and efficient in the wards. Established thus independently, although doubtlessly approved of and sanctioned by the governors, medical schools, like many time-honoured corporations have, from small beginnings, attained striking dimensions.

Such being the nature of their origin we may expect to find their relation with the hospital ill-defined, unstable, and capable of definite improvement. And that this is the case is testified by all whose attention has been directed to the matter. Indeed medical education in the metropolis, neglected by the public, unaided by the State,

abandoned by the hospital on the one hand, and ill-fed by the profession on the other, is feeble and dwarfed. Surely it should not remain so, nor indeed would it, were the question taken up in a public manner and with a vigour in keeping with the vital interests involved. It does indeed seem strange that, notwithstanding the extensive and valuable clinical material presented by the 4,500 beds contained in the large hospitals that lie within a radius of a mile of this room, medical education should eke out a struggling existence as contrasted with that it should have, or as compared with that of some of the more flourishing provincial schools. Moreover it may with reason be feared that unless some steps be taken, in the right direction, and that without delay, the London schools will come off badly in the competition now taking place with schools which not only confer such University degrees as lie within the reach of average intellects, but also offer striking attractions in their arrangements for the advancement and acquisition of practical and scientific knowledge. This unsatisfactory position to a great extent arises from the fact, that hospital managers are for the most part of opinion that medical education has little claim upon them and but slender connection with hospital administration, and therefore may be left to take care of itself. Such opinion is not likely to be weakened by the increasing financial difficulties involving our large hospitals, or by the recent increase in the number of special hospitals.

As a result, the inadequacy of school buildings, the comparative poverty of museums, and the deficiency of educational arrangements, are evidences of the hand-to-mouth existence of some of our metropolitan schools, and tell of the absence of any adequate working capital.

And this may be expected when we reflect that institutions, whose aims and responsibilities are of a public nature, are in reality private concerns carried on amidst all the difficulties of want of capital. For just as the onus of providing our sick poor with hospital aid is cast, not with an evenly diffused burden upon the well-to-do many, but with unjust pressure upon the few, so the responsibility of supplying medical education, unrecognised by its rightful bearers, is thrown upon hospital physicians and surgeons.

In the limited scope of this paper it is impossible for me to deal otherwise than briefly with some of the more important difficulties. We may however discuss them

under the threefold heading of Management, Building, and Finance.

Management.—Information on this point received from the metropolitan schools displays considerable diversity. Some are managed by a committee composed of the medical staff and lecturers alone. Others are administered by a joint committee formed of the staff together with the treasurer and certain governors, and in one instance the treasurer is chairman of the school committee which consists of the staff and lecturers.

These bodies meet from time to time, often with no regularity. In the interval between their meetings the secretary or dean of the school, who in most hospitals is one of the medical staff, and whose services are almost if not entirely honorary, is the executive. This arrangement is open to much criticism.

There can be little question but that the progress of a medical school, and the welfare of a hospital are retarded by a system which places the management of the hospital and school in wholly distinct hands. The school having interests, aims and responsibilities, parallel if not identical, with those of the hospital, should be managed by a board of which some of the lay members of the hospital committee form an integral part. By the adoption of such an arrangement matters having important educational bearings would attract somewhat more than the scant attention they at present receive from hospital governors, and those engaged in managing the school would become educated in some of the practical difficulties of hospital administration of which they are now ignorant.

Under such a conjoint management, greater attention, with more successful results than have been hitherto atained, might be given to the following amongst many other points:

The careful selection of the best candidates to fill the staff and other appointments;

The exercise of a systematic supervision over the numerous lectures, classes, demonstrations and methods of instruction, with authority to deal with such teachers as may not fulfil the duties of their respective posts;

The allotment of the resident hospital appointments as prizes to those students whose career in the school, judged from a practical as well as from a scientific aspect, merits reward;*

* Surely it is antagonistic to the interests of the hospital and school that these appointments should rest with individual physicians or surgeons.—T. G. S.

The disposition of clinical appointments;

The best arrangements for securing the attendance and practical working of students in the wards.

The provision of adequate clinical instruction together with suitable clinical material; and

The development of valuable museums and libraries.

At some hospitals insufficient attention is paid to many, if not to all, of these points.

With manifest advantage to all concerned such a conjoint board has been in operation for some years past at the London hospital. There the college board, which manages the school, consists of twelve members, of whom six are annually elected from the house committee from among its members, the chairman of the house committee being always one of them, and the remaining six are annually elected by the staff and lecturers from amongst themselves. By this arrangement the affairs of the school are conducted by a committee large enough to represent all views, and yet not so large as to hinder its capacity for business.

School Buildings.—The relationship between the hospitals and schools on this point is somewhat strained owing to the financial difficulties which beset the question.

The medical and surgical officers for the most part firmly hold that all buildings for teaching purposes should be erected by the governors in recognition of the benefit derived by the hospitals from their connection with the school, and seeing that these structures, being built on hospital ground and on insecure leases, become the property of the governors.

On the other hand the governors practically deny the claim and in effect say, 'Build your own buildings. We have no funds for such a purpose.'

The result of this short sighted policy, as might be expected, is evidenced by the ill-devised lecture theatres, inadequate class-rooms, overcrowded dissecting space, and insufficient museum, library, and reading-room accommodation, which a visit to our medical schools will reveal. And not only so, but apart from their inadequacy these buildings are in some instances placed in positions dangerous to the sanitary welfare of the hospital. Indeed the fact will hardly be credited, that in one hospital the dissecting-room is actually situated on the ground floor, within the building,

thus permitting its vitiated atmosphere to ascend and permeate the wards.

Another important responsibility, one hitherto much ignored and neglected, is that of providing suitable residential chambers for medical students, under authoritative management. The fulfilment of this duty in an adequate manner must act beneficially not only upon the students themselves, but also upon the hospital patients and its discipline.

Finance.—Our third and final point, Finance, is the chief difficulty of this as of most other questions; for the financial department of school management is on all sides embarrassed. From want of funds the instruction supplied is defective and behind the requirements of the day. The emolument connected with the various lectureships is oftentimes scanty, indeed oftentimes the work is honorary. These difficulties are increased by the cheapness of medical education.

To remedy these evils, the following suggestions are made:—

1st. The hospitals should provide the schools with suitable buildings, appealing to the public, if necessary, for the requisite funds. For these buildings a fair interest on the outlay involved might with reason be charged. Should the hospitals fail in this duty those who have the interest of the school at heart should make such appeal. Success has followed such efforts in the provinces, and would not fail to accompany similar endeavours in the metropolis.

2ndly. The fees derived from medical students for their education should be raised; and,

3rdly. The scale of the distribution of fees should be vested in the hands of the school managers, and should suffer such readjustment from time to time as may be deemed advisable by them.

In conclusion, I would at once meet the assertion that may be made by some here that many of these details have no bearing on hospital administration. With this I do not agree, for it cannot be denied that the welfare of the patients and the success of a hospital are definitely influenced by the character of its school as a teaching establishment. The interests of the two institutions are so inseparably intermingled that whatever improves the one benefits the other. If as a result of this Conference medical education in the

metropolis were elevated to its true position, the greatest benefits bestowed would be those received by the maimed and suffering sick for whose alleviation these charities were primarily founded.

Finally, it may be well to sum up the foregoing remarks by the following propositions, viz. :—

1. That medical education in the metropolis is insecure and ill-endowed, a condition which arises from—

a The peculiar origin of the medical schools ;
b The apathetic attitude of hospital governors ;
c The financial difficulties of the respective charities ;
d The absence of public support ; and
e Faulty administration.

2. That the medical schools are a necessity for the effectual working of our clinical hospitals.

3. That in order to promote a higher degree of efficiency in medical education, suitable to the requirements of the age, it is essential that considerable improvement should be effected in the relationship borne by the large clinical hospitals to their medical schools in connection with school buildings, museums, administration, finance, clinical teaching, lectureships and house appointments.

4. That the management of medical schools should be vested in a board upon which the lay governors of the hospital should be duly represented.

5. That well devised steps be taken to secure the funds necessary to place medical education and its schools in a position more in harmony with the requirements of the metropolis.

These, I venture to think, are not the least important of the many questions relating to hospital adminstration which loudly call for a full, wide, and searching inquiry at the hands of a Royal Commission.

Discussion.

Lord Powerscourt (Chairman of the Board of Superintendence of the Dublin Hospitals) said that a statement had been made by Mr. Burdett in an article in the March number of *The Nineteenth Century*, that the board exercised but a feeble control over those institutions, but the fact was that the board had

the power to go beyond making suggestions and recommendations to the governors of the hospitals. He was glad to observe that for the last few years during which he had had the honour of presiding on the board, they had made at first many suggestions, which had generally speaking been well carried out by the hospital authorities, and he ventured to think that a lay element, such as was contained in the board, brought fresh ideas into the management of the hospitals. The board was, as we well knew, appointed by the Lord Lieutenant, and he, the speaker, had endeavoured to infuse this lay element into it, by recommending some of the leading citizens for appointment upon it, not being medical men, and this, he considered, had strengthened the board. The annual report contained much more complete classified lists and statistics than it formerly did, and the advice of the board, he contended, contributed to the efficiency of those institutions, as large and important improvements had been carried out lately under their supervision. With regard to the medical schools, there was one formerly, attached to Stephen's Hospital, which the governors of the institution had suppressed, and the board inquired specially into the reason of this, and were informed that it was thought best not so have so many small schools detached, in connection with individual hospitals, but to concentrate the medical schools and work them on a larger and more combined system. This no doubt, was a great advantage to the pupils. The medical profession were fully represented on the board by a sufficient number of the most eminent physicians and surgeons, some of them unconnected with the hospitals which were under their care.

Dr. Tibbits (Physician to the Bradford Infirmary and the Bradford Fever Hospital) said that the medical staff of those institutions all took their seats at the board of management and at the Infirmary, two of them in rotation annually attending the house committee, to which five governors were nominated, making seven in all. They met weekly, and certainly not in a perfunctory manner. Five gentlemen attended, on an average, 45 weeks out of the 52. The election of medical officers to these institutions was part of their administration, and at the Bradford Infirmary a great improvement had been made in that respect within the last six months. Formerly the election used to be in the hands of the general body of subscribers, which involved useless expense ; but now it was entirely in the hands of the board of management, and of the staff. Even yet there might be an improvement. It would be better to have a special electoral body, as they had at the Fever Hospital, a body of 15 gentlemen being the electors of the honorary staff. He was

sorry to say that in the case of the medical superintendent the election was still in the hands of the board of management and the vice-presidents. An evil mentioned in the paper of Mr. Rawlings had been illustrated within the last six months. Vice-presidents were qualified by donation, and several, whom he had not seen at any of their meetings before, attended on the occasion of a recent election, and swamped the votes of those who knew more about the institution. Vice-presidents should be entitled to vote at any election, provided they had been present at six out of twelve monthly meetings of the board of management held the preceding year. Hospitals might be managed pretty much as railways are. There should be a general manager superintending the whole, and sub-managers for the medical, surgical, nursing, and domestic departments. If they were tobe properly man aged and conducted, every member of the working staff must be paid. The consulting staff ought to take their seats at the board and at the house committee, with the full understanding that they were not ornamental, but were working members.

MR. BOUSFIELD (King's College Hospital) said he was sorry there was no paper written by a governor or by a member of a committee of one of the London General Hospitals. In great measure it would be the opinion of the majority of the members of hospital committees which would practically settle the lines that the management of hospitals would eventually take. The opinion of the medical staff was of great importance. As long as we had our hospitals, principally supported by charitable donations and contributions, so long must those who provided the funds have a preponderating voice in hospital management. Dr. Bristowe's paper was interesting because it showed the progress and development of important hospitals; and it shewed that by a proper selection of medical men who were able to bring influence to bear, everything might go on satisfactorily. He had for nine years been a member of the King's College Hospital committee, and the unanimity shown during the greater part of that time, or the whole of it, had largely arisen from the fact that a large proportion of the medical men were members of the hospital committee. He believed that many difficulties would have occurred which might have produced feeling between the committee and the medical staff if these had not been members of the medical staff on the committee. The government of the hospital was practically a close one; the members of the committee had always nominated those who were to succeed to vacancies on the committee, and their selection had been approved by the governors. On the whole that had been an exceedingly good system, and they had got as good a selection of men to take an interest in hospital work, and to spend

a great deal of time on the management, as they would have got by any other system. At St. George's Hospital a different system existed; those who were governors had a right to attend. Practically the effect was the same as in a close committee; the same gentlemen always attended; but there was this disadvantage, that on the making of an appointment, or when feelings were aroused, a large number could come down and outvote those who took a constant interest in the work, and who attended the weekly board. If you wanted really good management you must have proper responsibility, by having a limited number responsible for the government on whose shoulders would rest the blame for any want of success. There was no doubt we were approaching a time when the whole question would have to be reconsidered. The mere fact that the money which had carried on hospitals up to this time was likely to fall short would direct attention to the way in which hospitals are governed. We were sure in time to have the State exercising at all events a controlling influence over the management of hospitals. The question of medical schools which were attached to great hospitals was important, and would deserve the attention of the State. If the Government determined to subsidise medical schools or hospitals—and it was rather the medical schools that ought to be subsidised—the Government would naturally wish to have some controlling power, and, directly the State got a controlling power over hospitals, immediately their autonomy or freedom of government would go. Just as poor-law guardians found themselves hampered in carrying on the work of their infirmaries by the Local Government Board, which acted advantageously in the case of those that were badly managed but prevented reforms and improvements in the well managed—so would the control of the State fetter the management of hospitals and the carrying out of reforms. While in badly managed hospitals, as in badly managed poor-law infirmaries, the control of the State would have great advantage, to a well managed hospital it would be found to be a disadvantage in checking improvements which could not be carried out in all hospitals at once. It would be found that the representation of governors in the way adopted in the case of King's College Hospital and a number of general hospitals was the best. The governors practically had little to do in ordinary cases. They simply ratified the nomination of members of the committee by the committee itself. The annual meeting of the governors was generally a farce. From time to time there arose important questions on which it was desirable there should be something like an expression of popular opinion. It was only by a meeting of governors on critical occasions that you could get popular feelings represented in hospital management. If this was done, and if at the same time the views and wishes of the medical officers were duly represented on the committee by the representatives of the medical staff, we had the best practical government of a hospital. It was impossible, in the

case of the London hospitals, to have a theoretically perfect system, but it was possible, by development and the introduction of improvements suggested by experience, to approach gradually to the best practical system.

MR. HENRY MAUDSLAY said that the wonderful diversity and distribution of hospitals and charities in the metropolitan area could be realised only by purchasing a map of London on which their positions could be indicated, and also by studying a book called "The Charities of London." The subject of hospital administration and distribution in the metropolis had been carefully gone into before St. Thomas's Hospital was built, at Lambeth, and such institutions had been established and supported by private charity up to this day. Yet some say that if they cannot be conducted with private resources, the assistance of Government, by means of a Royal Commission, would either be asked for, or it would be forced upon the managers and governors of all charitable institutions. If the charities were absorbed by the Government, they would have to be supported by taxation and connected with the political arrangements of the day. He strongly objected to the charities of England being absorbed by the Government. If any appeal were made to the Government it should be on the basis that the State should assist in their support, because the public health was the root of the question. The five large Royal Hospitals had their charters and organizations dating from Edward VI., and had worked well up to this day, and although their arrangements might in some respects go on with minor alterations and improvements from circumstances and old conditions, yet they were the result of the benevolence and beneficence of centuries, and exhibited a spectacle not to be found in any other country of the world. The private charities were the glory of England. Other hospitals he was connected with relieved distress in some of the poorest parts of London, but not only had they to attend to the necessities of their own poor, but patients from all parts of the country come to our London institutions for special diseases. If the management and maintenance of these hospitals were to become an affair of State, he believed that the present private subscriptions to them would be withdrawn. If our charitable arrangements were to be carried out by order of the Government, the springs of heartfelt gratitude towards God for our own health, and sympathy with the sufferings of the poor which prompted much of our charitable giving, would be shut up. When he was a partner in the firm of Maudslay, Sons, and Field, in order to render the best assistance in his power to the thousand men in their employ and to their families, he became a life governor of the twenty-six hospitals and other charitable institutions he had referred to. If it was said that he, and subscribers like himself, could not give their attention to the affairs of all, he replied that the general management of such institutions was

carried out by benefactors and honorary officers in whom he had confidence, but that he could attend on special occasions when his personal presence and assistance were required, when he could act on his own inspection and judgment, and from explanations that were made to him by the medical men, clergy, and other officers of each establishment. If the idea was that Government control would secure a better organization, he believed that was a mistake, because a government paid officer could not have the same sympathy with the poor as a person who had paid his own money for their assistance and benefit, and he was sure that Government absorption of the charities of England would dry up the sources of individual beneficence.

Dr. Alexander (Western Infirmary, Glasgow) said he was asked by his committee to attend this Conference. He was Medical Superintendent of the Infirmary, which contained 400 beds. He was not sure if he exactly understood what was meant by governors, because in Glasgow they had none. There, there was an annual meeting of the qualified contributors to the infirmary, at which the board of management was constituted for the following year. This board was composed of twenty-seven members, nine of whom represented the contributors, and these were appointed at the annual meeting. The other eighteen managers were appointed by various local bodies. Among those who have the power of appointing members of the board of management are the senate of the university, and the faculty of physicians and surgeons of Glasgow, and those bodies each returned two medical men; so that there were four medical managers. The board of management met monthly, and there was generally an attendance of at least half of the members. There was a house committee, which was almost a committee of all the managers. This committee met weekly, and was composed of about twenty members, of whom twelve or fifteen were generally present at the meetings. It was by this committee that the work of the hospital was practically carried on. Three of the medical managers were on the house committee. The business went on very regularly and smoothly at the meetings; and during the six and half years he had been connected with the infirmary, he did not think there had ever been any upsetting of the arrangements proposed by those who took the most active part in the working of the hospital. There were similar arrangements at the Royal Infirmary, Glasgow, where there were 600 beds. There were various other committees, and among them a medical committee consisting of the four medical managers and seven or eight managers; but the medical staff were not on the general or any committee. At one time at the Royal Infirmary some members of the staff were on the committee, but he understood the arrangement was not found to work well, so when the Western Infirmary opened in 1874,

a special clause was put in the constittiuon providing that no member of the staff could be a member of the board of management. On any question affecting the staff they were always called in and consulted. The responsibility for the whole government of a hospital devolved upon the medical superintendent who had supreme charge under the managers. That principle applied to all the large hospitals of Edinburgh, Glasgow, and Aberdeen. The appointments of the medical staff and all other appointments were made by the managers at whose board sat the four medica men already mentioned. There was, therefore, no canvassing of contributors, which was an undesirable, expensive, and wearisome thing. The arrangements had always worked satisfactorily, and there had always been pleasant relations between the managers and the staff. There were no difficulties about nursing, &c.; if the medical men saw anything they did not like they had only to let it be known and the managers would give it their fullest consideration. He was in daily communication with them; it was partly his duty to attend all meetings of the board and committees as a sort of medical assessor; and anything the staff wished to have brought before the managers could be brought before them either by notice through himself or by notice to the secretary.

The Rev. T. Birkett (formerly treasurer of the Cheltenham Hospital, and now Secretary of the West of England Sanatorium) said he had given great attention to the subject of hospital administration. It seemed to him that first of all there should be a small—and, if it was to be a thoroughly responsible body, a very small—executive committee of not more than seven members upon which certainly the medical staff ought to be adequately represented. It was said, and experience showed, that it was the tendency of these committees to become close bodies, self-elected from year to year, and personal feeling among friends entered so much into the question of election, that if you got a member who was difficult to deal with, and who was an obstruction, it was hard to get rid of him, or, if proposed, to prevent his election. Then the only appeal was to the governors, which was another word for subscribers; and such an appeal had well been described as a mere farce. It seemed to him that what was wanted in addition to a small executive committee was some body to come in between them and the large irresponsible body of subscribers or governors. There must be a board consisting of vice-presidents, the qualification being usually a donation of 50 guineas or upwards, and a certain number of elected members to which there should be the right of appeal, and to which all important questions of change of policy or extension, or any great matter which did not come within the ordinary routine of hospital management, should be referred. The board should elect the executive committee, and in electing it should vote by ballot, each member

writing the names of the member he would wish to elect for the year. By some such arrangement as this hospitals might get over many of their present difficulties. If the executive committee were a close body and worked badly, woe to the hospital that had no redress and no power of changing its management, and no appeal except to the general body of subscribers.

Mr. Joseph White (Consulting surgeon to the Nottingham General Hospital and member of the Weekly Board) said that the governing body of that institution was formerly a weekly board which was elected annually, but as the members were eligible for re-election, those who attended most regularly were re-elected from year to year, and comparatively little change was made. That board worked well, pleasantly, and laboriously for the institution. It was naturally thought, however, after some years, that some change might be introduced with benefit, and a change was made in the constitution by which one-fourth of the members of the committee had to retire yearly, so that the committee might be changed in four years. The consequence was it sometimes happened that those who were just getting into the work of the hospital, who were becoming interested in that work, and whose experience was becoming very valuable, were obliged to retire; and now he thought that some of the committee would be willing to go back to the former arrangement. The present constitution of the hospital was this: there was a general board of governors which met twice a year, consisting of donors and subscribers of a certain amount; there was a weekly board, which took the management of the house and its economy, and of all matters of finance; and there was an independent medical board, consisting of all the members of the medical staff, which had the control of everything connected with the welfare of the patients. The latter had the power to report not only to the weekly board, but also to the general body of governors, and these powers were generally beneficially exercised. The weekly board frequently submitted to the medical board questions which were believed to be specially within their province; and when it was found that such might be of benefit, conferences between the two boards were arranged. Such conferences were generally most satisfactory, and would probably become more frequent. The best possible feeling existed between the two bodies, and each derived benefit from the other whilst maintaining its own independence. The election of the house surgeon by the general body of governors had been found to be attended with so much trouble and expense to the candidates, that it was felt difficult to get the best men to come forward; but by a recent alteration of the rules the election had been placed in the hands of the weekly board, the medical board, and certain other governors, and this arrangement he believed would work well. He was quite sure that it did not do to change the weekly board.

and those having direct management of a hospital too frequently. There were questions of economy and of general management which could only be learned by long experience, and if there were frequent changes it would be difficult to get that experience brought to bear. The weekly board of the hospital had worked assiduously; certain members took special departments into their charge and instituted a searching examination into all items of expenditure and the cost of all articles consumed; and they adopted a check system which was very beneficial; but all this could be done only by continuous work. He felt strongly that the weekly board of a hospital must not be imperatively changed too frequently, and that the governing body must be more or less continuous.

Mr. Henry C. Burdett (Seamen's Hospital, Greenwich) said that the questions included in the papers under discussion embodied the main spring on which voluntary charity must necessarily depend. It was a matter of satisfaction that the subject had been opened by one so eminent and capable as Dr. Bristowe, who, with Mr. Timothy Holmes, prepared the first really exhaustive report upon the hospitals and dispensaries of this country. He was sorry that the relation of the hospital to the medical school had not been touched upon, and he regretted that Dr. Gilbart-Smith, who had taken much interest in the subject had not been present to read his paper. The result of his own experience was that a successful medical school meant a successful hospital. It had been said recently that the governors of Guy's Hospital were on the eve of acting on the belief that any body of governors in certain circumstances could say to the medical school, "We can do without you, and we decline to have anything to do with you;" but he believed that in abolishing the school they would have abolished all that was eminent in the medical staff, and such proceedings on the part of any body of governors would probably be the most fatal blow that could be struck at the efficiency of the hospital. St. Bartholomew's Hospital owed its new convalescent home mainly if not entirely to the sympathy which the eminent members of the medical staff had attracted to its work, and it was largely through their influence that the funds had been subscribed. As to the participation of governors in management, in London governors had been led to believe that their presence was required rather at the festival dinner than at the annual meeting; but festival dinners were often a delusion so far as the results were concerned, and the larger portion of the receipts at the dinner would be sent in without any such expensive proceeding. In the case of one London hospital, this point having been brought under the notice of the committee, they had decided tentatively to try whether they could not induce the governors to attend the annual meeting. This committee made the annual

meeting attractive by securing an eminent chairman and speakers, and substituted real business for fine feeding. The result was they found the seven-tenths of the whole receipts were still sent in, and in addition they received 20 per cent. more than the three-tenths supposed to be due to the annual dinner. The election of the medical staff was a most important question. None knew better than those connected with provincial hospitals the abuses under the old system. Contests were as severe and as expensive as parliamentary elections. He had had to indulge in an election of the kind; he knew the cost, the wear and tear, and the disadvantage, and he welcomed the change that was coming. In reference to the system of appointment he thought the one adopted originally at Birmingham was to be preferred. A special election committee was appointed under the rules. It consisted first of all the members of the committee of management, secondly, of all the members of the honorary staff; and lastly of a sufficient number of governors selected by ballot. The election committee so constituted consisted of 100 members. In one case the ballot took place after the annual meeting, and the committee was elected for a year. In another it was thought better, as the governors are selected by ballot, and were three-fourths of the committee, or 60 to 40, that the ballot should take place ten days before the election of a medical officer, so that every candidate should have a list of the election committee given to him at the same time. He believed that to be the best system, and it had worked admirably. He agreed with Dr. Bristowe that it was better the hospital staff should send delegates to the house committee, than that the whole staff should be members of the committee. It was a great temptation when a medical board was almost equally divided, for the minority to go to the members of the general committee and endeavour to use influence so as to obtain a decision contrary to that which had been arrived at by the medical board. In practice it would be found that two delegates appointed annually was the best form of representation. These gentlemen would go with the whole force of their colleagues behind them, and no committee was prepared to stand against a unanimous recommendation from their medical staff.

Mr. S. Leigh Gregson (Royal Southern Hospital, Liverpool), said he did not appear as a deputation from the hospital, but, being desired to speak, offered a few remarks from his personal experience. The way in which the institution was conducted had produced very satisfactory relations between the medical board, board of management, and the general board. The general board consisted of a president, three vice-presidents, a treasurer, two of the honorary medical officers (nominated by the medical board) and twenty other trustees. The general board met once a month and read over and confirmed all the minutes of the meetings

held by the board of management and medical board. The board of management consisted of ten members selected from the general board, and met weekly and had the care of everything relating to the economy and management of the house and patients. The medical board, consisting of the honorary medical officers for the time being, also met once a week to attend to the medical and surgical economy of the hospital. There were also three members of the general committee selected monthly to visit and report on all details of management, one commencing in the middle of the month, the next at the commencement of the following month, and the third commencing again in the middle of the next month, so that if any matter of importance required watching the chain of connexion in evidence might be secured. The general committee elect the house surgeons, matron, and all servants of the hospital, but to supply a vacancy in the honorary medical staff a special meeting of the trustees must be called, including all subscribers of £2 2s. and upwards, but the subscribers must have contributed the £2 2s. for twelve months so as to avoid a large influx of strangers for the simple object of voting at the election, which must be by ballot. The average number of beds occupied is 160; the total annual expenditure, £8,000; the yearly reliable income, £6,000; leaving deficiency to be met each year, £2,000; average cost per bed, £46 to £50; staff honorary medical officers, 7; secretary, 1; in and out-door staff, 60. It had been found most desirable to have a matron who has passed through a training for nursing, and a good practical housekeeper under her. He considered it very undesirable to have a hospital for more than 300 patients, and as a town expands and people leave the centre, the hospitals, he thought, should be closed, the land sold, and a new hospital formed in the district to which the people had removed. The same remark also applied more or less to churches and schools. The working of this hospital was so satisfactory that the speaker strongly recommended the adoption of a similar system elsewhere.

Mr. G. B. Lloyd (General Hospital, Birmingham), said that he was a lay member of the committee, and he did not attend as a delegate, but came to express his own views. Two large questions were before the Conference—one was where the money was to come from in the future, and the other was how the hospitals were to be managed. As regarded the former question, he had come to the conclusion that, just as our public asylums and elementary schools had come under local management, so hospitals must pass eventually from being private institutions to municipal management, under the local authorities in towns and counties. In almost every English speaking country except our own—in the Colonies, in the United States, and in Canada, he believed—hospitals were not private affairs, as they were with us; and the result of public management as compared with private manage-

ment was that about twice as many beds were provided in proportion to the population. The difficulties of tickets for free admissions were also got rid of. The General Hospital at Birmingham had existed more than 100 years ; and under its present management it had rarely been hard up for want of funds, but there was ample opportunity for good-natured discussion, and crotchets were allowed to be freely ventilated, and all serious quarrels were avoided. Another conclusion he had come to was, that it was best to have a good broad democratic basis. Every subscriber of two guineas —and there were some hundreds—was allowed once a year to take part in the election of the committee which consisted of about fifty. The honorary medical officers and the president and vice-presidents were members of it. The committee met once a month, and generally some thirty out of the fifty members would attend. The eight honorary officers could all attend if they liked. From the committee of fifty were appointed two sub-committees, the house committee and the finance committee. Each of these as well as the medical board had to lay its minutes on the table at the meeting of the large committee. These minutes were read, and any member could challenge what had been done by any of the inferior committees. The house committee practically managed the working of the institution ; and the medical gentlemen chose two of their body to serve as members on this committee. The four honorary physicians and four surgeons usually took it in turn to serve on this committee, so that each turn came round in four years. Anything that might cause friction was mostly talked over at the meeting of the house committee. Occasionally medical questions were referred by the large committee to the medical board, at which the four assistants had the right to attend, as well as the eight honorary officers. If, as frequently happened, there was a divided opinion, the subject had to be finally settled at the general committee. There were six visitors who were not members of any committee, and six who were members, so that there was generally one visitor, who was not on a committee, going round once a week with the opportunity of making a report which went before the house committee. Lately a good deal of money had been raised by the Hospital Saturday collection, and in the workshops by working men's committees ; and the working men had claimed that, as they contributed £5,000 a year to the various medical institutions of the town, they had a right to be represented on the several committees. This claim it had been thought right to concede, and therefore there would be on the committee of the General Hospital two or three members who individually might not be subscribers. This was a new departure, but he did not think any harm would come of it. It had been remarked that a medical school meant a successful hospital, but he was not so sure of that, but undoubtedly hospitals should be thrown open to students. The General Hospital at Birmingham was managed as far as possible in the interests of the patients, while some other

hospitals had been managed in the interests of the students rather than in the interests of the patients. He would not say that a successful medical school meant a successful hospital, but he should be sorry that a hospital should not be largely attended by students. The best critics of a large part of hospital management were the students, and the more they were admitted to a hospital, the more healthy it would be ; but that was very different from saying that a hospital was to be managed in the interests of the school. He did not look upon a hospital as subsidiary to the school, which would be putting the cart before the horse.

MR. D. C. GILMAN (President of the Johns Hopkins University, Baltimore, U.S.A., and late President of the American Social Science Association), said that the managers of the Johns Hopkins institution were free from the fetters and conditions that some English managers were involved in. A wealthy gentleman at Baltimore left a fortune of seven millions of dollars for the founding of a university and a hospital. The university had been in operation seven years; the hospital buildings, constructed on a costly and well considered plan, were now approaching completion. The university was governed by twelve trustees who were a close corporation, and filled vacancies in their own number. They designated five of their number as an executive committee, and referred to them a large part of the business. The hospital was also governed by twelve trustees, who also acted through committees. It was probable that a general superintendent of the hospital would be appointed, corresponding in station with the president of the university. The university and the hospital had now a joint committee who are engaged in considering an essential part of the plan, that is to say the organisation of a medical school in which the physicians would be called upon to give the students the benefit of the experience furnished by the hospital. Mr. Gilman dwelt still further on these points. He concluded by saying that he saw present at that meeting a gentleman who represented the charities of Boston, and was particularly interested in the administration of out-door relief, and another connected with the Presbyterian Hospital and other institutions in New York. Any conclusions that might be formulated by the Conference would be of service to managers in America and a benefit to mankind.

IV.—*Can the Systems of Free and Pay Beds and of Payment by Out-patients be successfully applied to existing Hospitals?* By Timothy Holmes, *Surgeon to St. George's Hospital.*

The above question is to my mind one of the most important, and one of the most difficult of those for whose solution we hope that a Royal Commission might collect adequate material. There can be no doubt that in the present day public attention has been strongly called to the many abuses which have grown around a hospital system whose general excellence we nevertheless admit and wish to increase and perpetuate. Those abuses have in great measure at least sprung from the attempt to relieve all the sickness of the poor by gratuitous charity, without any means of distinguishing between one sickness and another, or between one degree of poverty and another—or in fact of ascertaining the fact of poverty at all. It has been forgotten that there are forms of sickness which neither ought to be, nor can properly be treated by hospital advice at all. I mean such as depend on unhealthy hours, irregular habits, inadequate food, bad air, and such like. I doubt whether the present system of prescribing doses of physic for such cases by the score at a time in an out patient-room, does more good by the temporary relief that the medicine may produce, than harm by the ignoring and perpetuating of the real cause of the mischief. Then there is the grave question of the propriety or morality of encouraging the poor to neglect that provision for sickness, which could easily be brought within their means by the co-operative method applied during health, and which is so brought by the Medical Provident Association, of which I am a member. And there is also the fact (though in my opinion too much stress has been laid on it) that persons who are moderately well off do occasionally obtain hospital relief. This abuse, so far as it exists, affects the special rather than the general hospitals; and I believe that most of the persons so admitted enter with the privity of the medical officers.

To remedy these evils the pay system has been advocated, and has been in a measure adopted at St. Thomas's Hospital—though that experiment is faulty in a most important respect, which I will immediately point out. One other indisputable benefit would follow from such a change—viz.: that the rather numerous class of strangers who are

taken ill in London could have a refuge where they would be sure to obtain skilful treatment and nursing.

Such I take it are the main arguments for the change, and they are to my mind convincing as to its desirability, with one important proviso to which in the discussion of the matter hitherto too little, if any, attention has been paid. The existing hospitals are the schools at which medicine and surgery are taught: and this is a function which far exceeds in public importance the relief which they give to the sick poor. If in London every general hospital were closed to morrow, the sick poor would not suffer more than a temporary evil. The poor law infirmaries which now I believe have more beds than the general hospitals would be enlarged, and would admit a more urgent class of cases, and the sick poor (no doubt after a longer or shorter period of suffering) would be provided for. But medicine and surgery, perhaps the most progressive of all the applied sciences, and which depend for their progress exclusively on registered experience and observations, would have received a check, which would be felt by all classes of the community. It is consequently for the public interest that no change should be made in our hospital system which could impair the efficiency of the medical and surgical instruction given in those hospitals to which schools are attached. This condition has I fear not been kept in view sufficiently in the change which has recently been carried out at St. Thomas's. If I understand aright the arrangement made at that hospital, it involves neither more nor less than a withdrawal of the portion occupied by the paying patients from all the purposes of a public hospital—and the conversion of that portion (which I believe is the whole of one block of the building) into a private asylum, exactly similar to the Home Hospital in Fitzroy-square. The patients in the pay wards are neither visited by the staff, nor watched by the students of the hospital. Such a plan is not really one for the admission of paying patients into the hospital, but one for the conversion of a part of the hospital into private lodgings for sick persons. Against the extension or maintenance of such a plan I think all hospital reformers are bound to protest—not that I intend any reflexion on the governing body of St. Thomas's. I believe that the temporary embarrassments of the institution would have in any case caused the block to be kept empty, if it had not been occupied by the paying patients, and I assume as a matter of course that on the cessation of such embarrassments the wards will be restored to the sick poor who

have a right to them. Meanwhile the experiment may lead to interesting results bearing on the question which we are now discussing—how to combine the paying and gratuitous systems in a public hospital. But as at present carried out, it certainly is not an example of such combination. Meanwhile there are several general hospitals in London which have no medical schools attached to them, and in the country the connexion between a hospital and a school is an exceptional circumstance. In discussing the above question then, the first stipulation which in my opinion ought to be made, is that nothing should be done which would withdraw any cases from the observation of the students of a medical school. If people choose to go into a hospital to which a school is attached, it should be understood that their cases are to be subjects of medical instruction. Any loss of privacy which this arrangement involves is more than compensated by the increased attention which is thus secured to the patient, though of course to persons of very sensitive feelings the exposure before a number of medical students is distasteful, and such persons must seek more private treatment. If, however, the pay system were extensively introduced into those hospitals which have no medical school, the others might I think be left as exclusively free institutions.

If we grant this, the next question is how could the mixed hospitals be managed? So inveterate is the habit of considering that a hospital is an eleemosynary institution that even when the pay system is being applied to the general arrangements of the hospital no one appears to consider that the medical officers should be paid. Yet the justice and even the necessity of this condition must be acknowledged as soon as the case is stated. In St. Thomas's Hospital I believe that a paid resident medical officer has been appointed to whose services all the paying patients have a right if they choose to avail themselves of them. In other institutions it would probably be found more convenient to arrange with physicians and surgeons practising in the town, who would attend on terms agreed on between themselves and the hospital. The charge for medical attendance ought at any rate to be sufficient to obviate any complaint on the part of the medical men of the district of being undersold by the hospital.

Then follows the still more difficult question of the class of cases to be admitted. Unless some competent authority watches over the admission of the patients, the pay-beds will be crowded with cases of hysteria, chronic affections and

other trivial or imaginary complaints. The best plan as it seems to me is to leave this matter in the hands of the medical staff, or of a committee of medical men to whom the particulars of each case should be submitted and who should have the opportunity of seeing the applicant if necessary. Street accidents would no doubt always be admitted—as in fact they are to the general hospitals now—only that this admission, which is now a favour, and which is gratuitous, (though, of course, there are very few persons able to pay who do not give a donation in acknowledgment of the benefit they have received) would then be a matter of right, and would be charged for at a defined rate.

I do not apprehend that there would be any great difficulty in fixing the rates of payment. The experience of St. Thomas's Hospital, of the Home Hospital in Fitzroy-square, and of the Bolingbroke House Pay Hospital would provide data by which a remunerative rate could easily be fixed. A certain proportion of this would be set apart for medical charges and the rest would be paid over to the hospital, which would provide the nursing and the board and lodging. The nurses, however, must be under the orders exclusively of the medical staff—though not hired or discharged by them. Whether besides the patients who pay at a really remunerative rate there should be others who pay a portion of their expenses would be another serious question. There are many objections to such a course : but it is possible that there may be equal advantages. But I should be disposed to apply the same principle to all payments whether adequate or inadequate, viz., that a defined proportion should be set aside for the remuneration of the medical attendants.

The change no doubt would be a great one—as it would involve the abandonment of the eleemosynary system of hospital attendance which has become traditional among medical men, but without it I do not think it possible to try the experiment of pay hospitals satisfactorily, and there can be no logical or even sentimental objections to it. If a man is able and willing to pay for his treatment, he surely ought to pay the person who treats him, as well as, and even I should say before, the institution which only provides the place where he is to be treated.

I have purposely avoided many aspects of the question which will be better handled by others, in order to confine myself chiefly to two points which, I think, are not sufficiently noticed by most of those who have advocated the admission of paying patients into the existing hospitals, viz., 1,

that if such patients are to be admitted into hospitals having medical schools they must not be withdrawn from the observation of the students; and, 2, that the change will involve the remuneration of the medical officers who attend the paying patients.

Hitherto I have spoken only of the in-patients. The question of out-patients is, I think, much simpler. I cannot see any reason, either of charity, of public utility, or of professional education, why such cases should be treated on the paying system—unless as consulting patients; and this would be comparatively rare. To create a large department of people who would come for sixpence a time, would be to introduce an abuse greater than those we wish to abolish. The poor law dispensaries of course provided for those who can pay nothing. A plan like that of the Medical Provident Association will provide for the great bulk of the ordinary out-patients. There would remain the cases which require consultation; and these could come to the hospital—gratuitously to those with medical schools, and to the others on terms which could be easily fixed.

V.—*On the same.* By J. S. Wood, *Honorary Secretary of the Bolingbroke House Pay Hospital, and Secretary of the Chelsea Hospital for Women.*

This question, which is in the form submitted by the Council of the Social Science Association when they asked me to prepare a paper for this conference, does not, strictly speaking, indicate the direction of my inquiry. The difference between the question as it is, and as I propose to deal with it, is just that difference which exists between the words "contributing" paying-patients and "profitable" paying-patients. It is outside the province of a hospital to provide for patients who are in a position to pay considerably more than they cost. To treat them, the hospitals would encroach on the private rights of the medical profession. Even the bankrupt condition of a hospital is not sufficient to justify its committee in beginning trading in medical relief.

Whatever may have been the motives for founding our various hospitals—and the motives are as varied as the classes of disease they treat—there remains the one grand

object of their existence—the relief of the sick poor. Human suffering called hospitals into life and humane considerations must take precedence of such considerations as hospital finance, the patients' paying power or the clinical importance of cases. Besides, there are now distinct public institutions, such as Fitzroy House, founded by Mr. Burdett, where a 4 per cent. profit is made, and where there is provided every nursing accommodation and comfort for the class it is intended to serve. Such hospital homes are for paying patients properly so-called, but it is the "contributing patient" who probably can afford but a fourth of his cost, and his relation to the charitable hospital that we have to consider.

As a set off to the many stories one hears of the wholesale abuse of our sick charities it is pleasant to be able to testify to the very generally expressed feeling on the part of the artisan and wage earning classes, that they would prefer paying such a weekly fee as their means allowed to entering a hospital altogether as objects of charity. From my experience of the working of the Bolingbroke House Pay Hospital, founded by the Rev. Canon Erskine Clarke in the year 1880, I am led to believe that it needs but a general adoption of the principle of payments according to means, with a maximum limit, to very rapidly dispose of that charge of abuse for which hospitals seem to be held responsible. The principle involved is so important that it is engaging the attention of hospital managers abroad as well as in England.

I receive many letters of inquiry as to the working of Bolingbroke House, and within the last few days a letter has reached me from Australia asking for information as a guide to the managers of the Alfred Hospital at Melbourne, who contemplate introducing the paying system.

It is an oft-repeated fact that medical men are called upon to give gratuitous service more than any other professional or business men. There is no real reason for this. The doctor who labours gratuitously in the in or out-patient department of a hospital does so on the unexpressed understanding that he is attending the necessitous poor. He finds compensation for his loss of time in the professional advantages which every physician or surgeon gains by connection with a hospital. But his position is changed when patients are allotted to him who are of a class superior to the necessitous poor, and who yet may not be in a position to pay him his usual fees. It is for this class that the contributing system should be introduced into all hospitals, whether general or special. It is not sufficient to say that

such persons should go to the cheap class of practitioners. Sickness, with its possible termination in death, has a moral right to ask that the most skilful service should be available at a price within the means of the sufferer. Daily commodities we expect to pay for at their market price, but matters of life and death are surely not to be governed by any such rigid money value. Why force sick people to be recipients of charity, because they cannot purchase, by guinea fees, the skilled treatment they need? Therefore I say that hospitals for the sick should first, as of old, treat those immediately above the pauper class generously and freely, and secondly, supply the same medical skill and nursing to a very large section who would avail themselves of these advantages and gladly pay according to their means.

Another equally valid reason why the contributing system should be generally introduced is, that it fosters habits of "self-help" and independence among a people who have been taught to look upon free medical relief as a sort of birthright. In urging a policy of "self-help" in contradistinction to the prevailing "help-yourself" policy, it is essential to success that the contributing system should be adopted at all the hospitals. It is contrary to human nature to pay at one place for that which can be obtained elsewhere for nothing. The Western Ophthalmic Hospital has experienced the full truth of this. There are five ophthalmic hospitals, and the Western is the only one which has introduced the contributing system, and in consequence their out-patient numbers have been reduced by one-third of the former numbers under the free system. Patients have evidently drifted to the hospital in Moorfields, where 400 cases are sent gratis daily, and to the other ophthalmic hospitals.

It has been the custom to judge the value of a medical charity by the number of patients treated, and it is supposed that subscriptions flow in more readily to the institution showing the largest array of figures. This has led some institutions into the obviously unjust practice of calling "attendances" "patients," and so quadrupling the amount of relief they afford in the eyes of an indiscriminating public. While financial support is induced by a display of figures setting forth yearly increasing numbers, it would appear to be unwise for the hospitals to adopt any measure tending to lessen their numbers. It is very clear then that the great majority of hospitals must introduce the new system simultaneously.

Apart from the correctness of the principle of the contributing system, its adoption, under existing circumstances, is a

matter of sheer expediency. Most of our general hospitals havehad to bear a severe financial strain for several years past. But for this fact there would have been little inclination to consider the question of receiving contributing patients. If the necessity for some such expedient results in hospital managers fully recognising the value of the principle and putting it into practice, "the hospital crisis," as it has been called, will have served a very useful purpose.

I find by a calculation that the annual payments made by patients at sixteen of the ordinary hospitals amount to £7,356; and the average yearly expenditure to maintain those hospitals is £46,641; in other, words these sixteen institutions were supported to the extent of 15¾ per cent. by the small payments of those who received benefit from them. If the contributing system was in general use, an income of about £80,000 per annum would, according to the above calculation, be assured to the hospitals. This sum would almost meet the annual deficiency which now burdens our largest medical charities.

Another general objection is, that there is the possible danger of running to the opposite extreme, and that in the anxiety to become rich on the payments of the patients the fees would be made increasingly high and too rigidly enforced, and the really poor, treated as free patients, would become of secondary importance. This would be a vital error. Our hospitals must be primarily sick charities, and secondly provident institutions.

The fear that the non-paying patients may not be readily admitted whilst there are paying applicants, is dispelled by the fact that above 1,000 beds are now vacant every day in the general hospitals alone.

There seems no reasonable ground for anticipating that undue payments would be exacted, especially if a maximum rate was fixed. A majority of eligible cases would pay one-third or one-fourth of their cost, while the payments of those who could afford the maximum would probably give an average payment of two-thirds from each patient. What the general hospitals can hope to accomplish is the saving of expenditure, not the making of a profit. By admitting the class of persons received at Bolingbroke House, who, last year paid 73 per cent. of their cost, the hospitals would be saved the necessity for, and the expense of, appealing for charitable donations of an equivalent amount.

Here is a specific objection. I am told, that the charters under which some of the old hospitals are incorporated allow

of none but the necessitous poor being admitted. If the words "necessitous poor" signify those who are unable to pay any doctor, then the patients admitted to these hospitals are to a great extent not of the class described in the charters. As the charters are so far disregarded, small payments by patients may certainly be received without any dread of legal responsibility. The existence of a charter has proved no obstacle to the introduction of the paying system at St. Thomas's.

It is urged, too, that the food and the accommodation of contributing patients must be special, which would necessitate troublesome arrangements. It is argued that if a patient pays he has a right to expect something different from the ordinary hospital fare. The error of this contention lies in the fact that the patient is not asked to pay according to what he gets but according to his means. The patient who is receiving free treatment on the recommendation of a subscriber has been fully paid for by that subscriber, and therefore should be treated with equal generosity as the patient who is wholly or partially paying for himself. The difference is merely a distinction of words, one being called a voluntary subscription paid by the benevolent, and the other a contributing fee paid by the patient.

For the same reason no structural alteration or special accommodation would be necessary, except perhaps that two or three beds might be reserved in a separate room furnished in the simplest home-like manner for the reception of such cases as could pay their full cost. Medical men in their daily practice meet with cases of persons of very limited means who could just afford to pay their actual cost and no more, and whose cases would be best treated under the medical and nursing discipline obtainable only at a hospital.

A further stated difficulty in the way of admitting contributing patients to the ordinary wards is, that such patients would not be available for clinical purposes, and therefore hospitals having medical schools would be unable to join in any general scheme for receiving such patients. The difficulty is less real than imaginary. If the plan I am advocating referred to a very superior class of patient who paid large profitable fees, the difficulty would be real, for such patients could not be expected to submit themselves as clinical subjects; but as it is the same class of persons who already occupy beds in the general wards who would be asked to contribute, the charitable element would still remain only in a lessened degree. The patient would still be under an obligation to the institution,

and therefore may be reasonably expected to conform to the existing rules of its medical school.

No inquiry into this subject can be complete without the fullest consideration being given to the position of the medical men. If introduced the contributing system will, I am told, lessen the income of the profession; but as no reason accompanied the statement and as I cannot imagine any, this opinion must support itself. If profit making is the intention of the contributing system, it is obviously unjust to the medical profession that they should be asked to attend profitable patients without sharing the profits. I do not believe that as a body they would decline to aid a system which would save both the expenditure of the hospital and the independence of the patient. I am not shaken in my belief on this point, notwithstanding the failure of the "Poor Paying Patients" system at St. Thomas's Hospital. Last year the receipts from "Poor Paying Patients," who are received in the ordinary wards, were but £65 while the fees from patients at St. Thomas's Home amounted to £5,774 leaving a gross profit of £1,529. The failure among the patients in the ordinary wards is no doubt attributable to the fixed payment of one guinea weekly; and the consequent disfavour with which the staff viewed this arbitrary measure. Had patients been admitted by paying such few shillings weekly as they could afford the medical staff might have been expected to give a wise encouragement to the movement. If the contributing system will draw away the industrial classes from that type of practitioner who supplies unqualified assistance at sham "provident dispensaries" and induces them to pay their few pence into the out-patient department of a hospital, no one will regret the loss which that particular class of practitioner will sustain.

The question has been raised as to whether the contributing system will not invade the privileges of governors. The before-mentioned fact that there are 1,000 beds daily unoccupied disposes of the question, and while the free cases are as readily admitted as now, and no priority is shown in favour of contributing patients, the governors will welcome rather than object to the small payment system. All whom I have consulted on this point give a cordial approval. Governors pay well for their number of letters and the proportion used, to those issued to them, is very small. These free letters should be scrupulously honoured when presented by patients, though governors need exercise more care in recommending patients for free treatment.

An inquiry into what has already been done will after all

afford a more practical answer to the question at the head of this paper. In 1881 £28,909 were received by the various hospitals, convalescent homes, and medical institutions from the payments of the patients. The following are the percentages of payments made by patients (at those hospitals which now receive them) to the gross cost of maintaining all hospitals which share the Hospital Sunday Fund.

1879	...	3·40 per cent.
1880	...	4·08 ,, ,,
1881	...	3·99 ,, ,,
1882	...	3·97 ,, ,,

At seven general and twenty-seven special hospitals the paying system is practised in one form or another. I have tabulated under four headings the various systems of affording in and out-patient relief. The summary which follows the table shows how far the payment plan has been carried out and many, I believe, will be surprised to find that it has been so general. Nearly all the special hospitals adopt it, and some of them from the time of their foundation.

At six of the hospitals the question of admitting contributing patients is now under discussion by the committee, and from a systematic inquiry at all the London hospitals, I am able to affirm that the general feeling is strongly in favour of the *principle* of requiring patients to contribute according to their means. I have endeavoured to show that the difficulties suggested to me as likely to prevent the general introduction of a system of small payments are either non-existent or that they are not insuperable, and as the wisdom of the principle is so far conceded, it but remains for all the institutions to co-operate and simultaneously begin the practice.

From the table in the appendix attached to this paper it is evident that the same strange variety of methods are adopted in administering relief as in most other matters of hospital administration: but there is no evidence to prove that it is necessary to invoke the aid of a Royal Commission to compel hospital managers to adopt the contributing system. This wise measure of reform should be the result of this Conference and of others which, I hope, will follow it.

APPENDIX TO MR. WOOD'S PAPER.

Table showing the various Systems of affording In and Out Patients Relief at all the London General and Special Hospitals.

Name of Hospital.	Free System. Free treatment without letter.	Letter System. Free treatment if with a letter of recommendation.	Contributing System. Patients required to pay fixed charges according to their means.	Voluntary System. Patients asked to give what they can afford.
General Hospitals:				
Charing Cross	In-patients— Urgent cases.	In-patients. Out patients.		
St. Mary's	In-patients— Urgent cases.	In-patients. Out-patients.		
Seamen's, Greenwich	In-patients. Out-patients.			
French	In-patients— Urgent cases.	In-patients. Out-patients.		
Middlesex	In-patients— Urgent cases.	In-patients. Out-patients.		
German	In-patients / Out-patients } To German-speaking patients.	Out-patients— those not speaking German.	Beds for 5 men & 2 women, paying 31s. 6d. or 42s. weekly.	
Great Northern	In-patients. Out-patients.			
University	In-patients— Urgent cases.	In-patients. Out-patients.	Patients have occasionally been admitted, paying 21s. weekly.	
West London	In-patients— Urgent cases.	In-patients. Out-patients.		
King's College	In-patients— Urgent cases. Out-patients	In-patients.		
Westminster	In-patients— Urgent cases.	In-patients. Out-patients.		
North West London	In-patients— Urgent cases.	In-patients. Out-patients.	In and out patients, by payments, at the discretion of Lady Superintendent.	
London	In-patients— Urgent cases. Out-patients.	In-patients.	Pauper patients, admitted on payment, by the Guardians or others, of 2s. 6d. per day.	
St. Bartholomew's	In-patients. Out-patients.			
Guy's	In-patients. Out-patients.			

Name of Hospital.	Free System. Free treatment without letter.	Letter System. Free treatment if with a letter of recommendation.	Contributing System Patients required to pay fixed charges according to their means.	Voluntary Sys Patients aske give what they afford.
General Hospitals—*continued.*				
Metropolitan Free	In-patients. Out-patients.			
St. Thomas's	In-patients. Out-patients.		Beds for 24 men and 17 women, paying 56s. weekly, or "poor paying patients" in ordinary wards, 21s. weekly.	
Poplar, for Accidents	In-patients. Out-patients.			
Temperance	.. ..	In-patients. Out-patients.	Out-patients, from 1s. each attendance. In-patients — payment fixed by Committee.	
Royal Free..	In-patients. Out-patients.			
Homœopathic	Out-patients—if too poor to pay	In-patients. Out-patients.	Beds for 2 men & 2 women paying 42s. weekly. Out-patients — men 1s., women 6d. monthly,	
St. George's	In-patients—urgent cases— Out-patients.	In-patients.		
Pay Hospitals:				
Fitzroy House			Beds for patients paying from £3 3s. to £8 8s. weekly exclusive of doctor fees.	
Bolingbroke House			28 Beds for men women & children paying 10s. 6d. to £3 3s. weekly inclusive of medical attendance. With provident dispensary in same building as the out-patient department.	

Name of Hospital.	Free System. Free treatment without letter.	Letter System. Free treatment if with a letter of recommendation.	Contributing System. Patients required to pay fixed charges according to their means.	Voluntary System. Patients asked to give what they can afford.
Women:				
The Hospital for Women ..	Out-patients.	In-patients.	23 Beds for patients paying 25s to £3 3s weekly.	
Chelsea Hospital for Women ..		In-patients. Out-patients.	5 Beds for patients paying 10s.6d. to £2 2s. weekly. Out-patients pay 6d. weekly if without letter.	
New Hospital for Women ..	.. ..	In & out-patients must have a letter in addition to making a payment.	26 Beds for patients paying 2s. 6d to 10s weekly Out-patients pay 2d. weekly, and 6d. entrance fee	
Establishment for Gentlewomen..	.. ..	.. ..	25 Beds for patients paying 17s 6d. to 31s. 6d. weekly.	
Women and Children:				
Samaritan Free	In-patients. Out-patients.			
Royal Hospital for Children and Women		In-patients. Out-patients.	All In-patients pay: women, 1s. 6d. & children 1s. weekly; Out-patients pay 1d. weekly.	
Hospital for Women and Children		In & out-patients require letters in addition to making a payment.	14 beds for Patients paying 5s., 10s., or 21s.; Out-patients pay 2d. to 1s. weekly.	
Children:				
Alexandra, with Hip Disease ..			In-patients pay 4s. weekly.	
Belgrave		In-patients. Out-patients.		
Cheyne, for Incurable Children ..			In-patients pay 4s. weekly.	
East London	In-patients—Urgent cases.	In-patients. Out-patients.		
Evelina	In-patients.	In-patients. Out-patients.	Out-patients pay 1d. weekly.	

Name of Hospital.	Free System.	Letter System.	Contributing System	Voluntary Sy
	Free treatment without letter.	Free treatment if with a letter of recommendation.	Patients required to pay fixed charges according to their means.	Patients aske give what they afford.
Children—*continued.*				
Home for Incurable Children ..		In-patients require letters in addition to payment.	In-patients pay 5s. weekly.	
Hospital for Sick Children ..	Out-patients.	In-patients. Out-patients.		
North Eastern		In-patients. Out-patients.	In-patients paying 2s. 6d. weekly. Out-patients pay 3d. weekly, 4d. entrance fee.	
Victoria		In-patients. Out-patients.	In-patients admitted to ordinary wards by special consent of Committee, on agreed terms. Out-patients pay 3d. weekly and 1s. entrance fee.	
Lying-In:				
British		In-patients. Out-patients.		
City of London		In-patients. Out-patients.		
General		In-patients. Out-patients.		
Queen Charlotte's		In-patients. Out-patients.		
Fever:				
London, Islington		In-patients, being domestic servants of Governors.	Ordinary cases make one payment of £3 3s. Patients in private rooms pay £3 3s. weekly.	
Consumption:				
City of London		In-patients. Out-patients.		
Hospital for Consumption, Brompton		In-patients. Out-patients.		
North London		In-patients. Out-patients.		
Royal Hospital for Disease of Chest		In-patients. Out-patients.		

Name of Hospital.	Free System. Free treatment without letter.	Letter System. Free treatment if with a letter of recommendation.	Contributing System Patients required to pay fixed charges according to their means.	Voluntary System. Patients asked to give what they can afford.
Consumption—*continued.*				
Royal National, Ventnor.. ..	.. ..	In-patients pay in addition to letter. Out-patients.	Every In-patient pays10s.weekly.	
Infirmary, Margaret Street ..	.. ..	Out-patients.		
Throat and Ear:				
Hospital for Diseases of Throat and Chest, Golden Square ..	Out-patients.	In-patients. Out-patients.	In-patients pay from 10s. 6d. weekly, Out-patients pay according to means.	
Central London	In-patients. Out-patients.		18 beds for patients paying 3s. to 21s. weekly.	Out-patients themselves assess the amount.
Dental:				
Dental Hospital of London ..	Out-patients.	Out-patients.	Payment to be made for gold stopping.	
National Dental	Out-patients.	Out-patients.	Patients who cannot afford to pay a practitioner's fee are required to contribute from 2d. to 1s. according to their means.	
Ophthalmic:				
Central London	In-patients. Out-patients.			
Western		In-patients. Out-patients.	10 beds for men & 10 for women & children paying 5s. to 10s. 6d. weekly. Out-patients pay from 6d. weekly.	
Royal London	Out-patients	In-patients.		
Royal South London	.. ..	In-patients. Out-patients.		
Royal Westminster	In-patients. Out-patients.			
Paralysis and Epilepsy:				
National Hospital, Queen's Square	.. ..	In-patients. Out patients.	Beds for 10 women, paying12s. weekly.	

Name of Hospital.	Free System. Free treatment without letter.	Letter System. Free treatment if with a letter of recommendation.	Contributing System Patients required to pay fixed charges according to their means.	Voluntary Syste Patients asked t give what they c afford.
Children—*continued.*				
National Hospital for Heart, &c., Soho Square	In-patients. Out-patients.	In-patients. Out patients.		
Hospital for Epilepsy and Paralysis	.. ..	In-patients. Out-patients.	12 beds for patients, paying 10s. 6d to £4 4s weekly. Out-patients pay 1s. weekly.	
West End Hospital	.. ..	In-patients. Out-patients.	Cots for 5 children paying 2s. to 5s. weekly. Out-patients pay 1s. weekly.	
Skin:				
St. John's, Leicester Square	.. ..	In-patients. Out-patients.	In-patients pay according to means. Out-patients from 3d. to 1s. 3d. weekly.	
National Institution	Out-patients.	.. ..	Small sums wkly.	
Hospital for Diseases of the Skin, Blackfriars.	.. ..	In-patients require letter in addition to payment. Out-patients.	In-patients (women) pay 10s. weekly. Out-patients pay 1½d to 1s. 3d. weekly.	
Orthopædic:				
National Free Hospital for the deformed	Out-patients.	.. ..	30 beds adults pay 10s 6d. and children, 7s. 6d. weekly.	
Royal Orthopædic	.. ..	In-patients. Out-patients.		
City Orthopædic	In-patients. Out patients.			
Other Special Hospitals:				
Cancer Hospital, Brompton	In-patients. Out-patients.			
St. Saviour's Cancer Hospital		Out-patients.	In-patients pay 5s. with letter Beds provided at £1 1s. to £3 3s. weekly. Out-patients pay "trifling fee."	
St. Peter's Hospital for Stone	In-patients. Out-patients.		Beds £5 5s. weekly.	Out-patients assess their o payments.
St. Mark's Hospital for Fistula	In-patients. Out-patients.	In-patients. Out-patients.		
Lock Hospitals		In-patients. Out-patients.		

SUMMARY.

12 Hospitals adopt the Free System only.
9 ,, ,, Letter System only.
6 ,, ,, Contributing System only.
13 ,, Combine in some form the Free and Letter Systems.
21 ,, ,, ,, Letter and Contributing Systems.
10 ,, ,, ,, Free, Letter and Contributing Systems.
2 ,, ,, ,, Free, Contributing & Voluntary Systems.
3 ,, ,, ,, Free and Contributing Systems.

Hospitals.	Number in London.	Numbers which adopt the Paying System in some form.
General	22	7
Pay	2	2
Women	4	4
Children and Women	3	2
Children	9	6
Lying-in	4	—
Fever	1	1
Consumption	6	1
Throat and Ear	2	2
Dental	2	1
Ophthalmic	5	1
Paralysis	4	3
Skin	3	3
Orthopædic	3	1
Other Special Hospitals	5	2

VI.—*Can the System of Payments by Out-patients be successfully applied to existing Hospitals?* By Wm. Fairlie Clarke, M.D., F.R.C.S., *late Assistant Surgeon to Charing Cross Hospital.*

The subject that has been assigned to me is, "Can the system of payments by out-patients be successfully applied to existing hospitals?"

I am inclined to answer, "Yes, it can." But before I discuss this question, I desire to clear the ground by laying down four axioms:—

1. It is not good for persons to receive as a gift that which they may reasonably be expected to provide for themselves, whether it be medical attendance or any other benefit.

2. The work which any particular hospital is doing should be estimated by quality and not by quantity—by the effect which it is producing morally as well as physically, and not merely by the number of its patients.

3. As the treatment of disease forms the business of a great profession, the social and pecuniary interests of medical men must not be overlooked in the re-arrangement of the hospital system.

4. In any new scheme that is proposed the value of the hospitals as schools of medical education must be carefully secured.

But to turn to my subject. Let it not be supposed that the out-patient departments of our hospitals are an original and essential part of their constitution. On the contrary, they are a comparatively recent addition. Sir George Burrows, who is still amongst us, was the first who saw out-patients at St. Bartholomew's Hospital; and at that time several of our present hospitals, which are now large institutions, had not even been founded. In proposing, therefore, to make changes in the out-patient departments we are not dealing with time-honoured institutions, or disturbing long-vested rights.

The out-patients annually attending the hospitals and dispensaries within the metropolitan area considerably exceed a million in number. Of this vast multitude one half might, according to the best information within our reach, reasonably be expected to pay something for themselves.

But how are we to ascertain who could, and who could not, be expected to pay something for themselves?

I answer, this can only be done by regular and systematic inquiry. Indeed what I ask for may be summed up in two words, *inquiry* and *classification*.

But some persons object to inquiry. Why should there be any objection to putting a few test questions to each applicant? This is not only done at many of our most popular benevolent institutions—institutions for relieving poor gentlewomen, aged governesses, broken-down clergymen, orphan children, and the like—but the results of such inquiries are printed and published; why then should there be any objection to a few questions being put to working people, with no view to publication, but

simply as a guide to the inquiry-officer of the hospital, and to enable him to classify the applicants for out-patient relief?

Why should there be any objection? I'll tell you one reason why. Because admitting persons without inquiry, on the plea that sickness is its own introduction, swells the number of out-patients, gives ground for an urgent appeal in the advertising columns of the newspapers, and brings money into the treasury. The general public, who do not enter into these questions, think, not unnaturally, that the greater the number of patients the greater is the claim of the hospital on their support.

But we, who are intimately acquainted with the working of out-patient departments, know that this is a mistake, and that in very many instances the physical relief given is trifling, while the moral injury may be, and often is, the first step in pauperization.*

What, then, is to be done? In my opinion the first thing is for hospital managers to make up their minds to a self-denying ordinance—to determine that they will not suffer themselves to be led away by a desire for very large numbers, but that they will endeavour to sift and classify the applicants, even though it may be to their own apparent detriment, looking rather to the quality of the work than to the quantity.

Having then determined to institute a regular and systematic inquiry, how is it to be carried out?

With the exception of accidents and cases of emergency, all applicants should pass before a competent officer charged with the duty of ascertaining that their position and circumstances are such as to entitle them to charitable medical relief. Such an officer should be altogether raised above the class of the applicants themselves. He should be a man of some education and refinement, of a kind and forbearing disposition, but at the same time possessed of firmness, discernment of character, and tact. He should be thoroughly acquainted with the neighbourhood, and with all the charitable agencies in the surrounding parishes. Perhaps this officer might occupy the position of under-secretary to the hospital,

* The last Report of the Leeds General Infirmary says:—"Amongst the number of persons applying for relief as out-patients there were 2,099 whose cases were too trivial for treatment, who were consequently sent away; and about 150 were rejected as being in a position to pay for medical treatment." The number of out-patients admitted was 15,873.—W. F. C.

with such assistants under him as might be found necessary. In *Macmillan's Magazine* for August, 1873, I tried to show in detail how such a plan might be carried out. Difficulties, no doubt, there would be, especially at first; but if all the great hospitals could be induced to act together, I have no doubt a system could soon be devised which would act promptly and efficiently. And indeed some institutions are already at work upon this plan and they might be able to afford useful information and guidance.

But suppose that the managers of a hospital had got thus far, that they had instituted a regular system of inquiry, and that the patients had been broadly divided into two classes of those who could, and those who could not, contribute something towards the expense of their own treatment, what then?

I would have those who could not afford to pay anything treated gratuitously, as at present. This number would, I believe, after a time, become very small. The medical provision now made by the Local Government Board is excellent, and as provident and paying systems became better understood, the number who claimed charitable relief at the hospitals would be very small indeed. But that small number would receive more individual attention than is now possible, and their real poverty having been ascertained, they might be treated with a more liberal hand, and the medical comforts, which their cases often demand more than medicine, might be supplied.

Of the rest it would be found that some could afford to pay the ordinary charges of a general practitioner, while the great majority could pay for themselves according to the scale which is usually adopted at the provident dispensaries.

But where are they to find such provident dispensaries? In the *Contemporary Review* for April, 1879, I attempted to draw a picture of a great metropolitan hospital surrounded by its group of provident dispensaries. But as yet this is only a fancy sketch.

Several of the great London hospitals have free dispensaries situated close to them. Thus, the Royal General Dispensary is close to Bartholomew's Hospital, and the Public Dispensary in Clare-market is close to King's College Hospital.

Now I cannot imagine that there would be any great difficulty, if only public opinion were well instructed in this matter. I say I cannot imagine that there would be any

great difficulty in turning these free dispensaries into provident dispensaries, and then making them the first step in a series of dispensaries, which series should itself be the paying out-patient department of the hospital.

I am supposing that the process of converting the free into provident dispensaries should begin with those institutions which are even now almost appendages to the great hospitals which overshadow them.

But the process of change would not be likely to stop here. Many of the other free dispensaries in the central parts of London would be pretty sure to follow the same course and to become out-posts to the larger hospitals.

Thus there would be a central hospital with its out-lying provident dispensaries, having a close and organised relation to it, and doing the greater part of the work which is now done by its out-patient department.

If such a relation existed between the dispensary and the the hospital, there would be no difficulty in passing suitable and severe cases into the wards. The in-patient treatment might or might not be paid for (that is no part of my present subject) but the right to obtain it would be one of the benefits resulting from being a member of the provident dispensary, without its being necessary to seek a letter of recommendation when the pressure of sickness makes it most important that aid should be obtained at once.

The highest function of the hospital would be performed, and the sick person would receive, whether in the out-dispensary or in the wards, the treatment best suited to his case.

Thus, the largest proportion of the out-patient work would be done at the out-dispensary, while a small proportion only would remain to be carried on at the central hospital. That which was done at the central hospital would be done for those who had been ascertained to be destitute, and would be gratuitous. There would be much less, if any, of the crowding and long waiting that there now is, and which is such a drawback to the present system, while the patients themselves would receive more time and attention than is now possible, and the medical officers would have more leisure than at present to give clinical instruction.

At the out-dispensaries, where the work would be carried on upon the provident and paying principles, the medical officers would receive a salary in proportion to the number of cases they had to treat; and I, for one, have a firm conviction

that when regular and systematic work has to be carried on from month to month and from year to year, without any intermission, it will be better performed, if it is rewarded by a small salary than if it is not paid for at all.

In hospitals where the cases are severe, and therefore of medical and surgical interest, this may of itself be sufficient to secure the best attention of experienced men. But in the out-patient department it is otherwise. The frequent recurrence of trivial cases makes the work irksome and uninstructive, so that it is difficult to continue to apply oneself to it with freshness and vigour. When such work has to be done, I believe that the prospect of even a small salary is a useful stimulus.

Wherever the provident system has had a fair trial, the working classes have shown themselves very ready to avail themselves of it. The pity is that in London the excessive amount of free medical charity has hindered the system from having a fair chance. In his last Report for the parish of St. Jude's, Whitechapel, the Rev. S. A. Barnett says:—"An attempt has been made to start a provident dispensary. But the result is not satisfactory. The lavish way in which free (medical) relief is given in this neighbourhood is enough to damp any ardour in this direction." Mr. Barnett's experience has been shared by many other persons. Provident dispensaries have often been unable to maintain their ground, because of the indiscriminate alms-giving at the great medical charities.

But it may be said, would not the opening of such provident dispensaries, backed by the great hospitals, be injurious to the general practitioners of the district?

I do not think it would, and that for two reasons:—

1. The general practitioners might be invited to associate themselves with the out-dispensaries, and thus they would be brought into relation with the central hospital. This relation could hardly fail to have a beneficial effect on themselves by keeping them abreast with the most advanced medical science of the day. This again would tell upon their practice, and would raise their social and professional status.

2. The present system of gratuitous relief undoubtedly does the general practitioner incalculable injury. A large proportion of the patients now found in the out-patient departments have been drawn away from general practitioners by the temptation of obtaining gratuitous relief. One friend of mine told me that, when a certain special hospital was

opened in his neighbourhood, it reduced his income £100 a year. If the general hospitals were, as far as possible, to adopt provident and paying systems, the whole scale of medical remuneration would be raised; whereas now it is run down by the excessive competition among the medical charities.

But how would such a system as I have suggested affect the hospitals as schools of medical learning?

I believe it would materially improve the education and training which our students now receive. They would have all the advantages which they now have, and they would, in addition, have opportunities of visiting at the homes of the sick poor, and would acquire experience and a readiness of resource which would be of great use to them when they commenced practice. At present it often happens that a student is well acquainted with the features and treatment of rare forms of disease, but is ignorant of those minor matters which form the principal part of every day practice, because such minor cases are not admitted into the hospital.

It is the distinguishing feature of dispensaries that they undertake, when necessary, to visit the sick poor at their own homes. The students, therefore, who held the out-patient appointments, would attend at these out-dispensaries, under the appointed out-patient officers; and amongst other duties would have cases assigned to them to visit and to report upon to their superiors.

But though I am a strong advocate of the provident system of medical attendance, I cannot shut my eyes to the fact that it is vain to expect all working-class men and women to have sufficient thrift and forethought to enrol themselves in provident dispensaries. Yet sickness and accidents will befall the thriftless as well as the thrifty; and it is necessary to devise some plan whereby persons who are not enrolled members can have the benefit of out-patient treatment on payment of a suitable sum. Something of this kind is gradually finding its way into various institutions. As an example, I may mention that an influential meeting of medical men residing in the neighbourhood of Greenwich was held in April last with the view of re-modelling the Royal Kent Dispensary and introducing a paying branch. In this instance the payments proposed were 1s. a week in advance for patients attending at the dispensary, and 1s. 6d. a week for those requiring home visits. Some arrangement of this kind will, I have no doubt, have to be engrafted upon the provident dispensary system.

The question, how can we re-model medical relief upon a provident and paying principle has been occupying the attention of those who are interested in the welfare of the poor for the last ten or twelve years; and there can be no doubt that public opinion is undergoing a change. The number of provident dispensaries throughout the country has increased enormously, while a truer idea of the proper work of a hospital has been gaining ground.

In the article in *Macmillan's Magazine* to which I have already referred, I wrote :—"It requires some self-denial on the part of both the managers and the medical officers to sanction an alteration whereby the number of applicants would be diminished to any considerable extent. It is only natural that those benevolent gentlemen, who give largely both of their money and of their time to support and to manage a hospital, should wish to see the institution prosper; and we have got into the way of thinking that the chief test of prosperity is the number of applicants for admission. Thus it is almost thought necessary to offer some explanation if the number of patients one year is smaller than it was the year before; and an ever-increasing muster-roll is taken as a subject of congratulation. Surely, if this be so, it is allowing a mistaken charity to over-ride our patriotism—it is to congratulate ourselves upon what is, in fact, a mark of social decay, and of the unsatisfactory relation in which different classes stand towards one another. Strange as it may seem to some, it is clear to all thoughtful men that, if any amelioration is going on in the social condition of the lower orders, the dole-giving charities—whether their doles are bread or blankets or medical advice—ought to be diminishing the circle of their gifts and not enlarging it. Thus the managers of the hospitals, when called upon to initiate a reform, * * * are asked to allow their numbers to be diminished, and some of their applicants drafted off to other institutions."

When these lines were written, it would have been impossible to point to any hospital which was acting upon the self-denying principle there suggested. But now more than one example may be quoted.

(*a.*) At the last annual meeting of the Croydon General Hospital, the Chairman (J. T. Edridge, Esq., J.P.), in moving the adoption of the Report, said :—"As regards out-patients the number is slightly increased by five, but compared with some previous years the number is considerably

diminished. It seemed to him that they might look forward to a still greater reduction in the number of out-patients, for they could not fail to observe the great amount of good which the institution lately formed in Katherine-street, called the Croydon Provident Dispensary, was doing. He understood that it numbered some 1,500 members, although it had been in existence only 13 months."

Dr. Alfred Carpenter, in seconding the report, said:—"With regard to the out-patient department he felt in some little difficulty, because he had taken a prominent part in the establishment of the counter institution in Katherine-street. He did not do it in antagonism to the hospital, but his object had been one which he thought would commend itself to all those who were anxious for the welfare of their fellow men. His object had been to promote the interests of that dispensary and to urge upon the governors of the hospital the wisdom of connecting their own work with the work of the provident dispensary. His wish was to see the dispensary so arranged that the medical officers attached to the dispensary should have the first opportunities of getting upon the medical staff of the hospital. He should like to see an arrangement between the hospital and dispensary authorities, whereby those patients who belonged to the dispensary and could not be properly treated in their own houses should have priority as to admission into the hospital. He should like to see the officers of the dispensary seeking assistance from the medical officers of the hospital in consultation, and then if it was considered that a patient could not be properly treated at home, he or she, as the case might be, should be transferred to the General Hospital. This course would, he was sure, promote the principles of providence, for they would be encouraging the working classes to provide for themselves, to some extent at their own cost, medical assistance."

How refreshing it would be if similar utterances were heard at the annual meetings of the great metropolitan hospitals!

(*b*) The last report of the St. Albans Hospital and Dispensary contains the following paragraph:—"The number of out-patients has been decreasing during the past few years, owing, it is believed, to the establishment of the Provident Sick Club, the money payments for which have for convenience sake been received at the dispensary. The committee cannot regret this decrease, as it tends to shew a greater disposition to thrift among the working classes."

All honour to Croydon and St. Albans! These reports have happened to come under my notice within the last few weeks. But I doubt not that there are other hospitals and dispensaries which are carried on in the same wise and beneficent spirit. In various quarters, and in various forms, schemes of providence and thrift are being advanced. Indeed, as the working classes rise in social and political importance, such schemes become more and more necessary. Among such schemes none are likely to have a wider influence than those which relate to the care of health; and I believe we may now look forward with confidence to the time when medical charity will be confined within reasonable limits, and when the sick poor will, to a very great extent, be treated under provident and paying systems.

VII.—*On Hospitals in connection with Provident Dispensaries.* By Alfred G. Henriques.

The present Conference on the administration and management of hospitals affords a favourable opportunity for bringing under the notice of those connected with, and interested in, hospital management, the many advantages of that system of medical relief introduced by the Metropolitan Provident Medical Association for the establishment of provident dispensaries throughout the metropolis.

There are many points of contact between the hospital and the provident dispensary to which it would be desirable to direct attention, but on the present occasion I shall only speak of the 'Out-Patient Department' of the hospital in connection with the provident dispensary.

Among the many difficulties of hospital management there are none greater and none to which public attention has been more directed, than those of the out-patient department. The enormous number of patients presenting themselves for medical treatment offers difficulties apparently insurmountable as regards the physical conditions of time and space, that is to say, as regards the time at the disposal of the medical staff and the capacity of the waiting halls of the hospitals. These difficulties are ever present at all our large hospitals and are, with the growth of population, continually

increasing. Indeed the pressure in some instances is so intense that a radical change in the out-patient department cannot long be delayed.

At the hospital with which I am connected as a member of the house or governing committee, (the London Hospital) in the past year 62,437 out patients were treated, and that number, great as it was, did not include 30,000 cases treated for simple diarrhœa.

The London Hospital is one of those hospitals where the increase of the numbers of the out-patients is most marked and where urgent means are needed in order to deal effectively with the ever-increasing pressure.

It is almost needless to point out that it is quite impossible where the numbers reach such magnitudes that medical treatment can be efficient. In the year 1878 when the difficulties to which I am referring were far less than they are at the present day, Mr. Bridges in a paper published in St. Bartholomew's Hospital reports, called 'An Account of the Casualty Department,' gives a narrative half humorous and half pathetic of the out patient department at that hospital: that paper will amply repay careful perusal. I will on the present occasion only refer to the two astounding facts which he states—viz.: that he spent 1 min. 28 sec. on each patient, for 3 hours and 16 min. attendance on each day; and he admits that 'if he had devoted 10 min. to each patient, he would have required the whole 24 hours of the day and then have fallen hopelessly in arrear with his cases.' It would not be difficult to support that statement by corroborative testimony. For the same conditions obtain in every large metropolitan hospital.

The subject of the out-patient department of the London hospital has been very ably treated by a competent authority, Mr. Nixon, the house governor of that hospital. In a paper prepared by him for private circulation among the members of the house committee called 'Remarks on the System of Recommending Patients,' he admits that some earnest reformers have strongly urged the abolition of the out patient system altogether, regarding the difficulties as practically insurmountable. In that opinion, however, Mr. Nixon does not concur, 'considering an out patient department an essential part of the economy of a hospital.' Nevertheless, he proposes considerable reforms in the hope and with the avowed object of preventing over-crowding in the waiting halls, and insanitary or too continuing pressure.

on any of the hospital wards. I venture to think that that opinion is the true one, and that, to effect a great reduction in the numbers of out-patients, not total abolition of the out patient department is the true solution of the problem. Let us consider some of the more recent proposals in this direction. In order to lessen the overcrowding in the waiting halls, it has been proposed that all applicants for medical relief should pay a trifling sum either for medical attendance or for the medicine supplied. I believe that any payment by patients at a hospital is open to grave objection. By requiring payment, either for medical attendance or for medicine supplied, hospitals would become to a great extent commercial undertakings, and would enter into competition of an objectionable kind with existing dispensaries and even with the doctors' shops. I will not more than mention a legal difficulty that might arise, viz.: that when hospitals traded as huge medical dispensaries they would become liable to the laws that affect traders, or might even become liable to be registered as trading associations. However, it is clear that hospitals, by requiring patients to pay, would descend from their proud position and would exchange their philanthropic character for one more or less of a commercial nature. As soon as the trading element is introduced into hospital administration efforts will not be wanting in order to make the hospital pay; and whether or not success attend such efforts, the struggle to attain a commercial success will injure the character, affect the high position and materially degrade the functions of hospitals—which, it must ever be borne in mind, are institutions established in mercy for the relief of human suffering. I now venture to point out that there is a mode of greatly reducing the pressure in the waiting-halls of metropolitan hospitals without in any way interfering with the philanthropic character of the free hospital.

In the year 1880 the Metropolitan Provident Medical Association was founded by the Right Honourable James Stansfeld, M.P., Sir Charles Trevelyan, Bart., and others, for the purpose of establishing throughout the metropolis self-supporting and self-governing dispensaries. The scale of payments which has been adopted after much anxious deliberation is so moderate in amount that it is safe to say membership is brought within the means of the whole wage-earning class. Since the year 1880, nine provident dispensaries have been established directly through the efforts of the Metro-

politan Provident Association, or existing dispensaries have been taken over and adopted by the Association. Out of that number, at the present time only three are actually self-supporting, but three others are confidently expected to become so, in the course of the present year. It is found by recent experience that about 1,000 members will make a provident dispensary self-supporting, and obviously it requires time in order to canvass so large a number of members.

The advantages offered to members of dispensaries established by the Association are, that members can have a choice of duly-qualified medical practitioners; medical attendance at the homes of members, for themselves and for their families, drugs of good quality, the privilege to be transferred from one dispensary to another on change of residence. The management of such dispensaries is in the hands of members without any interference on the part of the Association after the dispensary is duly established.

The scale of payments has been adopted with reference to the ordinary payments made by members of benefit societies and is as follows :—"For members of benefit societies, 4d. per month. For non-members, 6d. per month. For a whole family, including husband, wife and all children under 16 years of age, 1s. per month. Members of benefit societies are entitled to exceptional advantages, for, by reason of such membership, they are known to practice thrift and self-denial, and, therefore, their lives are more healthful than the ordinary members of the dispensary.

Indeed, the system under consideration must be regarded as health insurance—comparable in principle to marine insurance and fire insurance, in which the monthly payment is the premium paid by the insurer to protect him from the expenses of medical treatment during illness. In a recent article the *Lancet* spoke deprecatingly of the miserable allowance made to medical men for the attendances where the contributions were so small. It appears to me that such a criticism was both unfair and calculated to hinder the success of a very interesting movement. It would be as unjust to speak of a paltry contribution of 1s. 6d. per £100, to protect us from the ravages of fire. In both instances, the contribution comes from the great numbers of contributors, but the indemnity is distributed among the relatively few, who are the sufferers.

In the case of the metropolitan provident dispensaries, the gross income is divided into two equal portions—one of

which is further divided among the medical staff, and is found fairly to satisfy them, and the other portion defrays the expenses of management including rent and the cost of the drugs distributed.

The success of the Metropolitan Provident Medical Association, though substantial during the three years of its existence, has confessedly been far less than was hoped or anticipated. The cause of this partial failure is due to the metropolitan hospitals, by means of their out-patient department, underselling the dispensary, or more correctly speaking, threatening to undersell the dispensary—if established; in other words the manifest advantages to the artizan class of first-class gratuitous medical attendance prevent the formation of a provident dispensary in the neighbourhood of any large hospital. The dispensary, if established in proximity to a hospital, would not succeed; it would be in open competition with such hospital. In fact it would be a competition of free medical attendance with medical attendance paid for—and in such a contest the result would not be doubtful. Still if the provident dispensary could be made to succeed, it would divert a vast amount of the work performed at the out-patient department of the metropolitan hospital. How can the two institutions be made to work together? At the present time there is an apparent antagonism, due to one institution providing free medical attendance, and the other requiring payment. That is the problem, and I venture to submit a solution. Before doing so, however, I beg leave to point out that the indiscriminate medical attendance as now provided at the out-patient departments of our metropolitan hospitals, is not by any means an unmixed good. Indiscriminate medical relief fosters the feelings of dependence, and encourages the receipt of charity. It undoubtedly lends itself to fraud, by permitting patients well able to pay to obtain medical attendance gratis, and it is believed that it gives the opportunity for a great deal of useless attendance in the waiting hall of cases that really require no treatment of any kind. All such cases would be dealt with summarily by the establishment of a provident dispensary.

These remarks refer only to medical cases, for which the establishment of provident dispensaries alone is intended. Accidents and surgical cases must ever remain to be dealt with at the hospitals. Now it is clear that the medical cases are so numerous that freedom from them will at once

relieve the pressure now existing at the out-patient waiting halls—and in such relief, I believe, will be found all that is now required.

In order to encourage, or even to permit, the establishment of provident dispensaries in the neighbourhood of the large metropolitan hospitals, it is necessary to abolish wholly and entirely the system of recommending patients for medical treatment at the out-patient departments. Governors of hospitals must abandon the privilege of giving away gratuitous medical advice, for unless that privilege is given up, I do not believe that any radical reform of the out-patient department is practicable. Having then abandoned the system of recommending out-patients for medical attendance, it will be necessary to reconstruct the out-patient department upon a new principle, and to limit it to accidents and surgical cases. It must then for such cases become a free hospital, requiring no recommendation and no governor's letter. Such a reconstruction would be entirely in accordance with hospital traditions and with the high functions which hospitals are established to fulfil. Changes of so radical a character must obviously be made by agreement by all the great metropolitan hospitals, together and at the same time, for no one hospital could abandon its system of recommending out-patients without imperilling its position before the contributing public, if other hospitals still retained that privilege for its governors. Assuming that such a general consensus of hospital authorities can be obtained and that the out-patient department is reconstructed at all the metropolitan hospitals in the mode suggested, it will be necessary to establish or encourage the establishment of numerous provident dispensaries in order to take over the medical cases hitherto treated at the out-patient departments. The Metropolitan Medical Provident Association will be quite ready and willing to do so, and under the conditions now under consideration such provident dispensaries could not fail to prosper. The kind of alliance between the hospital and the provident dispensary would probably become more and more intimate as mutual benefits began to be developed, but on the establishment of the provident dispensary in the proximity of a hospital the medical staff of the dispensary would be partly or perhaps wholly recruited from the medical staff of the hospital, and medical officers, common to the two institutions, would quickly introduce considerable inter-action between the two for mutual benefit. Beds within the hospital

would be filled by the serious cases from the provident dispensary, and, conversely, cases recovering would become dispensary cases for out-patient treatment. I only foreshadow occasions for mutual benefit and advantage, but many such may be readily imagined. In conclusion I will only again point out that the abolition of the existing out-patient department as regards all medical cases is the *sine quâ non* upon which all my argument turns and that no reform of the admitted evils is practicable until hospital governors can be persuaded to abandon their privilege of recommending patients for gratuitous medical treatment in the out-patient department. If these two changes can be effected, remedies for the existing evils will surely follow, and among the remedies to be proposed and, in the future, I trust, adopted, I am confident that the establishment of provident dispensaries throughout the metropolis will be found most efficacious in diminishing the existing pressure in the overcrowded waiting-halls at hospitals; and when it is recollected that (while the poor-law infirmaries supply free and gratuitous medical relief to the truly poor and indigent) the action of provident dispensaries in requiring moderate payment for medical attendance encourages habits of thrift and prudence, and cultivates feelings of manly independence which cannot but ultimately improve the social *status* and morally elevate the whole artizan class for whose benefit these provident dispensaries are mainly intended.

Discussion.

Sir Charles Trevelyan, Bart., said he thought it would be admitted that the main source to which we must look for the relief of our overburdened hospital system—not merely the out-patient part of it, but also the in-patient part—was the organisation of an efficient system of provident dispensaries. The medical treatment of the vast population of London, owing to the great increase of the population in the last half century, and the higher standard of medical treatment which was now required, was a far greater burden than private charity could bear. It had broken down in this impossible task, not only financially but also administratively. He need not describe the painful state of the out-patient system taken as a whole. After

hours of waiting in a crowded and infectious room, all that the patients could look for was an infinitesimal fraction of the time of an overworked medical man who never saw them before, and would probably never see them again, and who had to make his diagnosis in this very short time. The break-down of the system was also illustrated daily at the children's hospital. Poor hard-working women brought their sick children from distant parts in numbers that could not be attended to, and they had actually to be sent away in considerable numbers without any medical treatment. Another point was the pauperising influence of the system, and it was this which first attracted his attention. When he joined the Charity Organisation Society, he found that it was useless to attempt to encourage providence and self-respect while this wide gate to dependent pauper habits remained open. Provident dispensaries decentralised the present congestion and localised remedial action. They brought the medical profession into effective relation with the body of the people; they connected medical relief with the homes of the industrial classes. When they were established in sufficient numbers, the whole working class population would have a dispensary within easy reach, and, when a case required it, it would be attended to at the home of the patient. Provident dispensaries would extend to the working classes the institution of the family doctor, the family medical attendant, selected by the head of the family from the staff of local medical men attached to the dispensary, who would know the constitution and habits of each member of the family, and so would be able to advise and act preventively as well as remedially. The dispensary system would also introduce sanitation at the home. There was no mode in which sanitary administration could be carried out more effectively than through the medium of the family doctor, who was always ready to advise if anything was necessary to be done in order to make the home wholesome. Provident dispensaries also furnished a suitable means of introducing the skilled professional nurse to the people. Every malady would be promptly dealt with, so as to prevent serious mischief, in its commencement, and before it grew to require in or out-patient treatment. The body of the people would be maintained at a higher standard of health as the upper classes now were. The object of provident dispensaries might be described to be to make the advantages in regard to medical treatment that were enjoyed by the upper classes available for all classes of the people. As regarded medical attendance, sanitation, nursing, and pure and wholesome drugs, provident dispensaries, properly worked, did, as far as it was possible to do, place the lower and upper classes on a level in regard to medical treatment. We knew that the upper classes did not crowd the hospitals, and when dispensaries were established in

sufficient numbers, other classes would not do so; their attending hospitals would be rare; they would do so only in exceptional or what are called hospital cases requiring special skill or clinical treatment. The out-patient departments would be restored to their proper function of consultative administration, and the pressure upon both the in-door and the out-door departments would be less than at present. How was this to be done? The working class could not pay professional fees; they were ruined by doctors' bills; but apply the principle of co-operation and mutual assurance upon which the great friendly societies are based, and the difficulty would be at once solved. The friendly society provides sick pay, but the provident dispensary does better still—it prevents sickness as far as practicable.

The EARL OF CORK (St. George's Hospital) said that he had attended to listen and to learn, but, being connected with one or two London hospitals, he could not remain silent under some of the statements that had been made. It had been said that some of the hospitals kept up the number of their out-patients with the object of increasing their claims upon the assistance of the outside public. As representing St. George's Hospital he could say that the board had not put forward the number of out-patients with the object of getting subscriptions from the public. It was said that in some hospitals such large numbers of cases had to be dealt with, that only a very short time could be given to each. He did not know what was the case at other hospitals, but at St. George's the number of new out-patients was limited to 15 or 16 per day for each medical man; and therefore time and attention were given to every case brought before them. He ventured to think that as a rule this was the case in London, and the poor had their cases carefully looked into. As to the advantage of provident dispensaries, no doubt they would relieve the hospitals by reducing the number of out-door patients, but how could the hospital authorities discriminate between the cases that ought to receive free relief and those in which the patients were capable of paying for attendance? He did not know anything that would be more difficult to decide. It was objectionable to admit out-patients by governor's tickets; at St. George's they were not required; and the more important in-cases were received at once without governor's tickets. This he believed was the case, more or less, at every hospital. He believed that governors did not subscribe simply because subscribing gave them a right to send patients; they did so because they knew the great advantages conferred by a good hospital. He should like to know how these provident institutions were to be worked and paid for. The class who belonged to them were the superior class of working and

industrious men, the men who insured house and life; and how few there were of this class who came to the hospitals. He hoped the day was far distant when they would be turned away and refused the assistance they required. Must not provident institutions receive support from the public? He believed they would not be self-supporting, but must have subscriptions obtained for them. He heard some one say "No;" but still it had been stated that there were only three in the metropolis that were self-supporting. In that case others must receive support from the public; and if they did would not they be taking away subscriptions from the large general hospitals? While he would be glad to see the two institutions working side by side he believed there was a class of people whom the hospitals must assist as house-patients, and whom we could not expect to be largely reached by provident dispensaries. They must welcome any legitimate means of diminishing the number of out-door patients, and it ought not to go out to the public that there was any wish to maintain a large number simply for the purpose of inducing persons to subscribe. The managers wished to make hospitals not only schools of medical science but also institutions for assisting those who were unable otherwise to obtain medical relief; they wished to help such in the hour of sickness and the day of sorrow.

MR. JAMES CROPPER, M.P., said they were assembled in the belief that something required to be done to improve the financial position of the hospitals of London. He was inclined to think that all true financiers would seek for increased income by coming down to the people themselves. We saw the result of this in the case of the deposit banks, in building societies and in some charitable institutions when they were properly worked. It had been interesting to see how the day's discussion had drifted into the full recognition of the benefit of the provident system in London dispensaries as furnishing an indication of the best way of relieving the difficulties of hospitals. They did not altogether arise from the want of money. There never was such widely established liberality in gifts and legacies as at present. But more and more people were beginning to realise that gifts without some inspection, mere liberality without some careful examination of the object, were not in themselves beneficial. If it could be fully known to the people that liberality would be controlled so as to flow in well considered channels there would be no lack of contributions; but it was gradually becoming known that many persons were wrongfully deriving gratuitous benefits from hospitals, and people wanted to see that what they gave could be given to benefit people with-

out pauperising them. We could only point to the source which the provident dispensaries had begun to tap, to the pockets of the working people themselves. As even in the worst parts of London the working man existed in a condition which our forefathers would have thought affluent as compared with their own, so he would be ready to pay for the better treatment in hospitals which would be given when the doctor, the nurse, and managers considered the patient as a proprietor of the institution and a contributor to its maintenance. In Liverpool, Northampton, Coventry, Manchester, Derby, and other towns, there were already large self supporting provident institutions. Such an institution which he visited last year was attached to the hospital; the doctors of the hospital were the doctors of the provident institution; and the two were worked together. In Liverpool the medical society commenced their work by passing the following minute:—

"The indiscriminate bestowal of gratuitous medical relief interfered to a large extent with the rights and maintenance of medical men; and so far from being a real boon to the working classes, it encourages many of them to take advantage of institutions intended to be utilised only under special circumstances, thereby fostering in such persons acts of imposition and dishonesty, which lead too often to the sacrifice of self-respect and to improvidence and pauperism."

The best result he thought would be attained if there were for London a mixed governing body representing the interests of each institution, to prevent the clashing and the competition which he feared now existed, and at the same time to study and promote the interests of hospitals and their patients. He was glad to find that the number of hospitals in London and the neighbourhood that were now receiving money from their patients was 41. If the system could be made general, if every patient according to his means paid something, the well to do people paying most, the deficiency in the revenues of the hospitals would soon be supplied. It would be found beneficial to combine two methods of subscription to provident dispensaries—a monthly payment and also a small charge for every attendance. In one case which he (Mr. Cropper) knew well the members paid sixpence per family per month and also sixpence for every attendance of the doctor; thus no man could think he was paying too much for his neighbour's benefit, while no doctor could think he was being imposed upon by being sent for in trivial cases. He believed that the source was one from which real relief would come for our hospital difficulties. If this meeting could inaugurate an annual hospital co-operative meeting at which the different hospitals should be represented and form a board of manage-

ment, we might hope to have some solution of the difficulty by which in future funds might be obtained with more regularity and without injuring the independence of the working classes.

DR. ACLAND, D.C.L., F.R.S., (President of the Medical Council) being called upon, said that he, perhaps, had heard too much to be willing to plunge into the discussion at a moment's notice. The problem was a very tangled one, involving social, political, and medical questions, and it was only by free discussion that the truth could be arrived at. He heard with astonishment that there were medical institutions for the relief of suffering which sought to increase their finances by publishing over-statements as to the number of their patients. If that were so, God help them, for they did not know how to help themselves. In this country institutions prospered by doing good work, and not by shams of any kind. He had paid great attention to the subject thirty years ago, when he wrote a paper, and, after all that had passed, he should have little to add to it and nothing to take away. Being a hospital physician he saw many acknowledged evils, and he observed this curious phenomenon, that in some old institutions there was a positive unwillingness on the part of many persons to remedy them. The reason appeared to be that most hospitals, like the one to which he was attached at Oxford, were independent institutions, and were jealous of their independence. The great hospital system of Great Britain began about a century and a half ago, and became pretty general throughout the country. It was entirely a voluntary effort, and Montalembert mentioned it, as one of the greatest honours of England, that the benevolent care of the suffering sick depended upon that voluntary effort. But that was not so strikingly the case now. There had sprung up a class of excellent practitioners who, being supported by the State, were State officers, and who were in charge of the poorest necessitous sick, somewhat disparagingly called paupers. There was no adequate distinction drawn between them and those of the working classes who were able and willing to pay if there were a system under which they could do so. He was greatly impressed by what fell from Mr. Cropper, who stated, partly from experience and partly from knowledge otherwise acquired, that the secret of solving their difficulty was a frank union between the hospital and the dispensary system. He tried to introduce this plan some years ago at Oxford, but failed, as neither the hospital authorities nor the dispensary would then listen to it. He endeavoured to persuade the hospital to allow the use of their out-patients' hall, and to dispense the prescriptions of the medical officers of the dispensary the same as if they were attached to the staff; but the hospital authorities would not hear of it. But the gentleman who succeeded him at

the Radcliffe Infirmary, Dr. Darbyshire, to his great honour, not only saw all the medical out-patients of the hospital, but attached himself to the provident dispensary, and worked a portion of the town as a dispensary officer also. This seemed to him to be one of the directions in which we should find a remedy for the great difficulties which all acknowledged to exist in providing for the enormous suffering among our population. He was aware of the fallacy of applying the practice of a small provincial town to the metropolis ; you could only argue that the same principle might be applicable to some extent. He could quite imagine a system in which the dispensary officers should be connected with the hospital, and should visit the poor in their own homes, sending to the hospital only such cases as ought to go there. In many hospitals there were numbers of cases which had better be out, while there were others under dispensary treatment which could be far better dealt with in hospitals, but could not be got in. If the two departments were united, and if there were friendly relations between the medical men themselves, if the hospital received the cases that required its treatment, and if others were attended to at the homes of the patients, he could not help thinking we should find in the principle of this arrangement a means of settling this very difficult matter. He tried unsuccessfully to get students to visit the poor in their homes in Oxford. This was done at Edinburgh, and with immense advantage to the students, because they would have to treat them in their homes in after life. Many students were absolutely ignorant of the habits of poor families, and such ignorance was a disadvantage to them in their early practice. One of the advantages of a connection between the two staffs would be that the hospital students, under supervision, could go about among the homes of the poor, and that would be a blessing to the poor and to the students also. This was the way in which that great man, Professor Alison, of Edinburgh, formed his character of physician, philanthropist, and philosopher by working as a student in the hospital and in the homes of the poor.

Mr. Mackenzie Chalmers (London Fever Hospital) said that this hospital had been worked for some years partially, and during the last two years exclusively, on the system of receiving payments from patients. It took in over 1,000 cases a year. Perhaps fever hospitals could not be taken as types of other hospitals ; many conditions applied to fever hospitals which did not apply to general hospitals, where there was not the same necessity for isolation. As regarded the very poor the fever hospital had the Government behind it. The London Fever Hospital became a paying hospital two years ago because the Metropolitan Asylums Board established hospitals

for paupers or for those with relieving officers' orders. It was then for the private hospital to provide for those above that class. It was found that there was a deserving, honest, hard-working class who desired to pay something, but could not pay anything like the cost of a long infectious illness. Everyone was called upon to pay three guineas for the whole period of about 43 days, the average cost to the hospital being about £9 10s. If an application was made for a remission or a reduction of the fees, the case was investigated by the committee, and in some instances, such as those of daily governesses and servants whose masters could not help them, and persons whom it would be cruel to send to pauper hospitals, the applications were granted. It was found on the whole that that system worked exceedingly well. The patients themselves were very proud of not being paupers, and in the majority of cases they contributed willingly, even if they could only afford a guinea. Subscribers who became governors by subscribing a guinea had the right of sending a servant at any time free, and similar arrangements were made for large subscriptions with clubs, hotels, and houses of business. There was a third system of providing rooms for patients, and in these cases the hospital was free from the difficulties which beset other hospitals. Generally a medical man was exceedingly glad to get a case of fever into a hospital. It was found that the system of private rooms was a most useful one. It was a rule that when a medical man sent in a case he was entitled to continue to visit it and to keep it under his eye, provided he visited in consultation with one of the medical officers. As a rule, medical men preferred not to visit professionally but to come and see a patient as a friend. In certain cases in which a medical man thought there were peculiar symptoms, or that advantage would result from his attendance, he continued to visit the case in consultation with the medical officer. The operation of this rule obviated many of the objections that were sometimes urged against the advantages of hospital treatment to patients who were willing to pay for them. An incidental advantage of the system of taking patients who repaid their cost to the hospital was that it increased the number of those who were interested in the hospital, for the committee was now to a great extent composed of those who had been paying patients. This was a system which worked easily. Those who had been patients in the hospital understood the administration of it, and knew its necessities. The committee seemed to get on without many of the troubles which arose in some other hospitals as between medical officers and lay members who had or had not special knowledge. If the system of paying beds or paying wards could be carried on with discrimination in a general hospital it would be a very great advantage to the public. Speaking as one who

had been a hospital patient, he would much rather be nursed in a hospital than outside. The position of a bachelor who was taken ill was by no means an enviable one. The hospital still had a certain number of cases sent in by the sanitary authorities, but there were often cases that ought to be sent to the hospitals of the Asylums' Board. There was some difficulty in mixing the very poor, and those who were not quite cleanly, with more respectable people; and it was a serious question whether the paying patients should not be kept separate from those sent in by the sanitary authorities.

MR. C. RADLEY (Metropolitan Provident Medical Association) said the Earl of Cork seemed to infer that there did not exist an out-patient evil, but his own experience produced a contrary conviction. In many London hospitals people were crowded together in very large numbers every day. They were subjected to long weary hours of waiting, which to a healthy person must be objectionable, and to a sick person might often be dangerous. Lord Cork seemed to think that the provident dispensary system must be supported by the money of the wealthy, and that it might draw off contributions from the larger hospitals. Even if that occurred it would be an arguable question whether the money was not being directed in a better channel and being better applied. A certain portion of the money of the wealthy ought to be devoted to the erection of provident dispensaries, and so give poor people a start in order that they might be able to help themselves. It was just possible that, great as was the good done by our hospitals, money might be more usefully applied than to keeping people in a state of chronic dependence. The Earl of Cork seemed to think that the provident dispensaries helped those who did not require relief, and to question the propriety of giving to the self-respecting man who insured his house and his life. He hoped and believed there was a growing disposition to discriminate between those who were provident and those who were improvident in similar circumstances. Surely the man who maintained his respectability by forethought and care was as deserving of help as the spendthrift. The question was not so much, could the paying system be applied to hospitals as, ought it to be so applied? There was a wide distinction between in-patient and out-patient departments. It might be fairly assumed that no man should go to a hospital if it could be prevented. Sickness ought not to be centralised in large institutions if it could be avoided; but, of course, there were many in-cases requiring treatment that could be secured in a hospital. Why should a man avail himself of such advantages as a pauper when he might not be a pauper? In such a case he might be allowed and should be required to pay

something towards his support. With regard to out-patients the question became altogether a different one. Any payment at all in that direction involved an increase in what was already too extensive a practice. If you removed a certain taint of charity, if you encouraged the impression that 6d. or 1s. a week gave a right to the advice of eminent men, you would cause more people to come to the out-patient department, and if you created an income in this way, the question would arise how far the medical advice should be gratuitous. If a large income were provided, some claim would be made by the medical staff to a portion of the fees. If this were granted grievous harm would be done to local practitioners as there would be set up a powerful trade establishment, with all the prestige of a large hospital, where people would pay small fees to the injury of the outside profession. A strong argument why institutions should be localised was that, if the malady were trifling, there was a waste of time on the part of the patient and of medical strength and ability in dealing with the case. If a person suffering from a serious malady, or having in him the seeds of a serious disease, became an out-door patient, the probability was that in time, however good and careful the treatment might be, he would have to keep his bed. It was not possible for all the people who became laid up to be removed into hospital. What happened in some cases was that when the malady became serious and required the most tender treatment, the man was forced to shift for himself, to give up the hospital doctor, and to go to a local practitioner who laboured under the disadvantage of taking up the case without knowing what had been done previously. These things led him to believe that when it was necessary or profitable to establish paying departments for in-patients, it was exceedingly advisable that we should attempt to localise rather than to centralise the treatment of out-patients, and it could be done easily by well-arranged provident dispensaries bringing medical attendance to the doors of our working people, without appreciable pecuniary pressure.

Mr. Thomas Ryan (Queen Charlotte's Lying-in Hospital), said that for 130 years the hospital had been administered on the free system, but it was now in contemplation to introduce payments by the patients according to their means. It had been remarked that it was necessary that this change should be introduced by hospitals simultaneously, as it was contrary to human nature to pay in one place for what could be got for nothing elsewhere. This theory however presupposed that the poor desired to shirk the responsibility of paying, even when they were able; but his experience tended to show that this was not so. Poor people were quite willing to pay according to their means if the matter

was only fairly placed before them. He also thought that if the hospitals waited for simultaneous action in this matter, it was vain to expect that any progress would be made. The governors of his hospital had lately talked over the means by which they could form an opinion on the subject. He suggested to them that it would be a good plan to ask the patients their own views, and this was accordingly done, and the result of inquiries, extending over a period of three months, was, that four-fifths of the in-patients were not only able and willing to pay something, but were anxious to do so as far as their means would allow. Of the out-patients, who were really poor and needy people, one half were able and willing to make a small payment. The average amount these patients were willing and able to pay was: in-patients, 5s.; out-patients, 1s. 4d. It might be interesting to say here that the in-patients who stayed about a fortnight cost 37s. per week each (this included mother and child), and the out-patients cost 6s. each. It had been remarked that if patients paid, their food and accommodation must be of a special character as compared with that for free patients. In this connection he was glad of an opportunity to say that his committee, in laying down the lines on which this system was to be tried at their hospital, had made it a fundamental principle that 'no difference is to be made as to accommodation or treatment between those who do and those who do not pay.' Other rules were that the payments by the patients were to be voluntary, that governors' letters of recommendation were to be required as hitherto, otherwise single women of a class who were not fit objects of the charity might present themselves for admission simply because they were prepared to pay; that the maximum payment that would be accepted was £1 for in-patients and 2s. 6d. for out-patients; that patients able to pay more could not be considered proper objects for the charity: that a form was to be inserted in the letter of recommendation, to be filled up by the recommending subscriber, stating his opinion as to the ability of the patient to contribute towards the cost of her treatment.

Mr. Bousfield said it had been abundently proved that there were very great difficulties and abuses generally throughout London in connection with the out-patient departments, and it was a waste of time to attempt to prove it. The difficulties in the way of hospital committees dealing with the matter were very great indeed. First there were the objections in the minds of charitable people who thought that any number of out-patients could be treated. Lord Cork seemed to think there was little difficulty anywhere; but a large number of out-patients were sent away every day from St. George's Hospital. The noble lord

admitted that each doctor was only allowed to take so many, and it followed that the rest must be sent away. The question arose, on what principle were they excluded? One ground might be the results of investigation as to the means of the persons who asked assistance. Or they might be rejected on purely medical grounds; and such rejections were made daily at St. George's and St. Thomas's. It seemed a hap-hazard system and yet it was the only one on which rejections could be made. The members of hospital committees could be called upon to attack such a system and to reduce the number of out-patients if they were sure that there were some means by which they could provide for themselves proper treatment; but until there was something like a network of provident dispensaries all over London connected with the hospitals, the hospital committees would not feel they were in a position to restrict the number of out-patients. Therefore an association had been endeavouring to spread provident dispensaries and to take the steps which must precede the reform of the out-patient departments; and gentlemen who took an interest in the reform could not do better than support the movement. The success of it would enable the committee of a hospital to say to every working man who was able to pay a small sum monthly: "There is an institution in the neighbourhood of your home in which you can be properly treated for ordinary diseases, and if the doctor who attends you considers that yours is a fit case for hospital treatment we will take you in." This plan would help the medical schools of the hospitals by sending them only cases calculated to instruct the students. Lord Cork seemed to be of opinion that it was only the better portion of the working class who could belong to the provident dispensaries; but it was not so. Many of the members of them were in receipt of very small wages. In addition to enabling them to obtain good medical advice, the dispensary educated them in providence and stimulated them to independence. In some of the dispensaries already formed, the working classes were beginning to repay the capital which had been expended in their formation. One was formed at Croydon two years ago, at a cost of £390, and already the members had taken means to provide £250 of that sum, in order that the money might be used for the erection of dispensaries in other parts of London. Before the hospital out-patient department could be effectually reformed, we must have a system of provident dispensaries to which the people could go.

On the motion of Sir Rutherford Alcock, seconded by Sir Charles Trevelyan, a hearty vote of thanks was at this point accorded to Sir Fowell Buxton for his services in the chair during the day.

Sir T. Fowell Buxton, in acknowledgment, said it had been interesting to him to listen to the discussions on a topic with which he had acquired some familiarity in association with Sir Charles Trevelyan. On some points he had heard opinions expressed with which at the moment he did not agree. He had been glad when the declarations made on some points had been taken up and called in question as they had been by Lord Cork and others. From his experience of the working of one large hospital in London he did not think that the selfish motives which appeared to be attributed to managers in one paper had any influence upon their proceedings. In the making of desirable changes there might be difficulties to overcome which sometimes were not seen by the public and sometimes not by the medical staff; it was necessary in such cases to gain the concurrence of one class or another; and that was one of the causes of delay in effecting changes which he should like to see. Still he hoped that the oldest of those present would live to see important changes in the dispensing of medical relief through our hospitals.

The Conference then adjourned until the next morning.

SECOND DAY.

JULY 4TH.

The Chair was taken at 11 a.m. by Mr. Francis S. Powell, a Past President of the Health Department of the Association, and the following papers were then read:—

VIII.—*The present financial Difficulties of the Metropolitan Hospitals: Their Cause and probable Results. Hospital Finance and Audit.* By HENRY C. BURDETT.

I propose to commence with the second branch of my subject viz.: *Hospital Finance and Audit.*—Hospital Finance, that is to say, the plan upon which the expenditure of our hospitals has to be controlled and the income raised, is a subject of the gravest importance not only to all who are concerned in the management of these institutions, but to the whole community. Extravagant expenditure means diminished usefulness, discredit, decay, and probable death. Economical expenditure, using economy in its true and best sense, means increased usefulness, intelligent public support, efficiency, abundant increase, and adequate extension: increased income and adequate extension, because economical expenditure will induce the managers of a given charity to spend wisely, to make necessary extensions, and thus to secure that amount of public support which will enable them to afford adequate relief in the best possible way. I take it that at the present time in the metropolis few hospital managers realise the importance of treating the financial management of their institutions in a thoroughly business-like and intelligent way. Now-a-days it is not only necessary to advertise daily in *The Times* and to trust to the goodness and abundance of the relief afforded, but those hospitals and institutions which are mainly dependent upon voluntary subscrip-

tions for their maintenance must periodically, *i.e.*, every three months, prepare a budget estimate of the income and expenditure for the ensuing three months with the view of ascertaining how much expenditure will have to be faced, how much income will probably be forthcoming, and how the deficiency, if deficiency there be, is to be met. In America, where there are few rich endowments worth speaking of to-day, and where when hospitals were first established there were no endowments at all, it is not surprising to find that this system of frequent estimates and careful expenditure forms the basis upon which all the largest and best institutions are conducted.

In considering the question of the present financial difficulties of the metropolitan hospitals, it became necessary to examine the accounts of these institutions with the view of ascertaining the amount of deficiency which exists at such institutions to-day. Before going into the subject matter of my paper, however, it may be well here to state that the difficulties of the task assigned to me have been considerably increased by the varied, involved, and I think I may justly say unsatisfactory systems upon which the accounts of many of the hospitals are at present kept. In but few instances is a balance sheet presented at all. Frequently all that is forthcoming is a statement of the receipts and payments for the previous twelve months, but from which statement are sometimes excluded the receipts from legacies, the amount of stock sold or purchased, and other important items, so that in such cases it is difficult to form an idea of the actual receipts and payments in any given year. In one instance the payments are given in various columns under the heads of debts for 1881, payments on account of 1882, debts of 1882, total cost of the year 1882 paid and unpaid. Under the head of payments on account of 1882 a total figure is given which corresponds with the total of the receipts on the other side of the account. These two columns shew an excess of expenditure over income amounting to £5,892. In the columns headed debts of 1882 is shewn a total excess of expenditure over income of £8,525, whereas if the figures given as representing the total cost of the year 1882 paid and unpaid are accurate, the actual receipts for the year ending December, 1882, exceeded the expenditure by a sum of £605. It would be interesting to know how a deficiency of £5,892 in one column becomes a deficiency of £8,525 in another column, and an excess of income over expenditure in a third column

of £605. At another general hospital the receipts are only made to include receipts from annual subscriptions, dividends, donations, and some special funds, legacies being altogether omitted, the difference between the receipts and the total expenditure being shewn in the accounts as follows:—

To capital;—for excess of expenditure over income, £11,808. No capital account is published in the report, so it is difficult to trace what inroads have been made upon the invested property, but in another page the legacies received during the same year are shown to amount to £5,888, so that the actual amount of capital expended on maintenance during the year was not really £12,000, as shewn in the accounts, but in reality less than £6,000.

At another general hospital the accounts are made to shew an excess of expenditure over income of say, £3,000, and this excess appears year after year, though there are no means of ascertaining from the report how this deficiency has been met, or by what means the hospital committee are enabled to maintain a large charity in efficiency when they every year make a loss of at least £3,000. It is, however, unnecessary for me to multiply such instances here, and I will content myself with the statement that for the purposes of this paper I handed over the reports of sixteen metropolitan general hospitals to a skilled accountant who is familiar with all classes of accounts, with a request that he would be good enough to draw up for me a statement shewing the deficiency or surplus on the year's working at each institution, the amount of legacies received, the amount of legacies invested, and the amount of stock sold or purchased, as the case might be. After devoting an entire morning to the study of the accounts he brought them back to me with a statement that although he had called in the aid of another accountant, they had failed to prepare the required statement in a satisfactory form. I then went into the matter with him, and as the result of many hours' work I have prepared the tables which are appended to this paper, and upon which the statements contained in it are based. That these tables are absolutely correct, I should hesitate to affirm, though they represent the exactest particulars which can be ascertained from a study of the published accounts of the hospitals to which they refer.

There can be no doubt that it is desirable in the interest of each institution that the accounts which it publishes should

be prepared upon the simplest and most intelligent system, and that they should state the exact financial position of the charity to which they refer. I am the last person to dispute that it may be desirable, in the interests of a charity, to have a bad balance-sheet rather than a good one for presentation at the annual meeting. No doubt it is sometimes, if not always, the best thing for such an institution to have a good cause and a bad balance sheet. But this is if anything a practical age, and philanthropic people are beginning to realize that if they are to give wisely to charities, they must try and understand something about the position which those charities occupy and the work which they do. It therefore happens, as I have frequently had occasion to know, that a fearless statement of the exact facts, whether the balance-sheet be good or whether it be bad, providing the work undertaken is a good work, and in the public interest, is the very best appeal which can be issued in the present day. I therefore hope, in the interests of the hospitals, that as one result of this Conference, we may get an agreement as to the best and completest system of keeping hospital accounts, and that the best and most carefully conducted charities will decide to adopt it.

Hospital Audits. Turning now to the question of the credit of hospital accounts, I find that the professional auditor is not necessarily, if ever, a panacea for the abuses which have resulted from imperfect and inefficient audit of accounts. It was only the other day that a leading firm of professional accountants prepared and submitted for my inspection draft accounts and a balance-sheet of a charity which I do not hesitate to say were false upon the face of them. I refused to pass this statement, and on referring it back to the professional accountants they pointed out that it was necessary to show a considerable deficiency on charitable accounts, and they had prepared the balance-sheet on that theory. Another firm, which is largely concerned in the audit of charitable accounts, suppresses all evidence of the transactions which take place in capital or invested property account, because they hold that the governors of the hospitals are not concerned with such matters, and that it is sufficient to show from time to time that the hospital possesses some invested property, and wholly unnecessary to shew from year to year how much has been saved out of income, or how much stock has been sold to meet current expenditure.

These things should not be. No charity ever profited by wilful suppression of the truth, and there is no system in my opinion so justly to be condemned as that which fails to report to the governors all that takes place in connection with each year's working. Again, it must be borne in mind, that however bad amateur auditing may be, two of our noblest charities have within the last five years been robbed to a considerable extent by their officials without detection in either case, although in both instances the accounts were audited by professional accountants. I will not dwell upon these defalcations, and I simply mention them to show that no system of audit is proof against the dishonesty of a high and trusted official. If I were asked what is the best form of charitable audit, I should say an audit equal to that which is carried out by the Exchequer and Audit Department under the supervision of Her Majesty's Treasury. Anything more searching or more complete than such an audit as this I have failed to discover, but I believe that few committees would willingly submit their accounts to so rigorous and exhaustive a system. Failing this, it seems to me that a mixed audit is the best, that is to say an audit where a firm of professional accountants are associated with one or perhaps two governors, the latter being specially selected for their knowledge and capacity. This system secures that the auditor thoroughly does his duty, and that an explanation is forthcoming of every doubtful item. Professional auditors for charities have failed where they have proved a failure because they have not been paid adequately for their services, their work having in consequence been hurriedly and imperfectly executed.

The way in which the audit of hospital accounts is at present neglected has been well and pithily shown by some inquiries set on foot, I believe, by *The Philanthropist* a new but useful monthly periodical devoted to the interests of charities. From this statement it appears that out of 54 institutions only 15 employ professional auditors, and that at 5 hospitals the accounts are audited by the hospital officials themselves. That any official should be allowed to audit his own accounts is a remarkable fact which surely needs neither comment nor condemnation. If however the combined system which I have here proposed were universally adopted, no official would be allowed to audit his own accounts, because the auditors would consist of a professional accountant, employed and paid by the committee, and two

independent governors specially selected for the purpose. This system of audit has been tried in one or two instances, and has succeeded admirably, and I therefore commend it for general adoption.

Present Financial Difficulties of Metropolitan Hospitals.—Turning now to the present financial difficulties of the metropolitan hospitals, their cause and probable results, I approach a subject of great and pressing importance, and one of no little difficulty besides. The more I have thought on this question the more I have become convinced that had my subject been confined to the present financial difficulties of the metropolitan general hospitals it would have been serious enough. But when I thought of the financial difficulties of all the metropolitan hospitals, upwards of one hundred in number, I must confess that the more I considered the question, the more it appalled me. However, I have done my best to ascertain the facts in relation to these institutions, and I venture to submit those facts, and some conclusions and suggestions, for the consideration of this Conference.

Taking the general hospitals first, I find that the 14 leading general hospitals contained 3,054 beds, and relieved 30,504 in-patients during the year 1881. In the year ending December 31st, 1882, the actual deficiency, including the sale of £16,000 of stock, amounted at nine of these institutions, in round numbers, to £40,000. At the other five there was a surplus of income over expenditure amounting to £6,600. Now this deficiency of £40,000 in one year at nine metropolitan general hospitals does not represent the total excess of expenditure over income at those institutions, because the income expended includes no less a sum than £69,700 received from a most uncertain source—legacies. If these were excluded, therefore, the total deficiency at the hospitals in question in one year would amount to £109,700—a sum which, if continued year by year, would absorb the whole of the invested property of all the general hospitals of London at the end of less than 10 years from the present date. Now I find, on a close examination of the accounts over a series of years at various hospitals, that up to and including the year 1873, the metropolitan general hospitals seem to have had, on the whole, prosperous times. But during the last ten years, for various reasons, there is no question that although the amount of work done by these institutions is represented by a considerable increase in the amount of in-patient relief each year, the various

sources of income have tended to decrease, and the sales of stock have consequently increased in frequency and amount. Thus, to take a single example, one of the general hospitals, founded in 1839, had an invested property of £20,801 at the end of the year 1868; in 1876 the amount of invested property had increased to £42,824, in spite of the fact that in the interval the hospital had been the arena of very serious nursing disputes, which had caused many to withhold their support. On referring to the invested property account of this hospital for the year ending December 31, 1882, it appears that it now only possesses £31,236, so that the actual absorption of capital in the ordinary maintenance of the hospital during the last six years in this institution amounts in round numbers to £12,600. This may be taken as fairly representing the experience of more than one or two of the general hospitals, and it is a matter which may well call for the serious consideration of all who are interested in these institutions. The two returns which accompany this paper give particulars of the work done in the in and out-patient departments, the amount of money spent upon management, the total income, and the chief sources from which that income was derived, and the total expenditure of sixty-eight metropolitan hospitals, general and special, for the years 1873 and 1881 respectively. From this table it appears that the amount of relief afforded to in-patients, taking the whole number of hospitals, has increased by 29·6 per cent., although the bed accommodation for the whole metropolis has increased by 17·7 per cent. only. On the other hand there has been a decrease in the number of out-patients equivalent to 2·4 per cent. in the charities under consideration. The number of beds provided by 16 general hospitals has increased 14·9 per cent., and the number of in-patients relieved by 23·2 per cent. At five chest hospitals the bed accommodation has increased by 23·3 per cent., and the in-patients by 23·9 per cent. These figures afford eloquent testimony to the fact that the beds provided by the consumption hospitals are much more fully occupied than those of any other hospitals in the country. The beds provided by the eight children's hospitals have increased 55·9 per cent., and the number of in-patients by 67·8 per cent. The number of beds provided by five women's hospitals has increased by 56·2 per cent. and the number of in-patients relieved by 104·9 per cent. At nineteen special hospitals the

number of beds has increased by 12·6 per cent., and the number of in-patients by 25·6 per cent. At seven convalescent institutions, all of which afford relief to metropolitan cases, the number of beds has increased by 23·1 per cent., and the number of in-patients by 47·3 per cent. At one group of institutions only, viz., the 4 lying-in hospitals, has the bed accommodation provided decreased by 12·9 per cent. In spite of this decrease in the number of beds, the number of in-patients treated has increased 5·9 per cent. I think, however, it will be readily admitted by those most competent to give an opinion, that it is satisfactory to find that the tendency is to diminish the number of beds provided by lying-in hospitals, and to increase, as we shall see presently has been the case, the amount of relief afforded in the dispensary or out-door departments of these charities.

It has been stated that the number of out-patients has decreased by 2·4 per cent.; that is to say, the general hospitals now see 4·2 per cent. fewer out patients than they did nine years ago; the consumption hospitals see 5·8 per cent less; the children's hospitals have reduced the amount of out-patient relief they afford by more than one fifth, or by 20·8 per cent. and the women's hospitals see 4·8 per cent. fewer out-patients than they did formerly. This is satisfactory, and it is not a little remarkable that the only two groups of metropolitan hospitals which have increased the number of out-patients during the last nine years are the lying-in hospitals and the special hospitals. As before stated, the fact that the managers of the lying-in hospitals are reducing their number of beds, and increasing their out-patient relief by sending their midwives and doctors to the homes of the poor, is highly satisfactory on hygienic and public grounds. Again, the fact that the out-patients attending 19 special hospitals have increased by 17·9 per cent. in the last nine years, seems to me to prove beyond question the popularity of the graduated pay system of hospital relief, for the out-patient departments of many of the special hospitals are at the present time almost, if not entirely, self-supporting, owing to the fact that the patients who frequent them are allowed to pay according to their means for the benefits they receive.

Turning now to the question of the income, expenditure, and management expenses of the metropolitan hospitals, I find that in 1873 £31,400 was expended by 67 hospitals upon management, that is to say, upon the salaries

of secretaries, clerks, and others engaged in the management, and in advertisements, printing, stationery, postage, law charges and incidentals, and this expenditure had increased to £40,311 in the year 1881. The results of this expenditure were to secure a gross income in 1873 of £394,655, of which £227,010 was derived from annual subscriptions, donations and other voluntary sources, £150,058 from endowments and legacies, and £15,232 from patients' payments. In 1881 the income received by these hospitals had increased to £429,582 viz.: annual subscriptions, &c., £215,458, a falling off of nearly £12,000 a year in nine years; endowments and legacies, £185,507; and patients' payments, £20,436. The total expenditure in 1873 was £338,295, and in 1881 £411,767. That is to say, in the year 1873 the gross total sum received by the hospitals exceeded the total sum expended by £56,360, and in 1881 the gross income exceeded the expenditure by £17,815. These figures are very misleading, because the voluntary income, that is the annual subscriptions and donations, decreased by 5·1 per cent. during the period under consideration, whereas the income derived from endowments and legacies increased by 23.6 per cent., and that from patients' payments by no less than 34·2 per cent. In other words, the increase was largely derived from legacies, a most precarious source of income, and for this reason many charities refuse to recognise legacies as income. Legacies are liable to be left subject to the acceptance of certain special conditions, and the times of payment are most uncertain and irregular. The truth of this will be apparent when it is stated that one general hospital, for instance, received £7,754 from legacies in 1873, and £2,784 in 1881, whilst another hospital received £3,268 in 1873, and £29,568 in 1881. Again, in the case of the 16 general hospitals, the whole of the income of £220,070 received in 1881 was not really available for current expenditure, because of that sum £32,681 was given for special purposes, and not for ordinary expenditure. Thus, instead of the 16 general hospitals having a surplus of £4,101 in 1881, they had really a deficiency of £28,580.

If space permitted I might go on to shew similar results in the case of the other groups of hospitals dealt with, but I think it will only be necessary to state that instead of the total income exceeding the total expenditure for the year 1881 by £18,000 in round numbers, there was really a deficiency approaching £40,000. It must be apparent, therefore, to the

most casual observer that if the metropolitan hospitals are to be left with an excess of expenditure over income of anything like £40,000 per annum, some, and possibly very many of them, must perforce cease to exist before long. In fact, most people will agree with the statement of the gentlemen engaged in the administration of the principal hospitals of London, who memorialized the Home Secretary in 1879, 'that as a large proportion of the medical charities are 'dependent wholly or in part on the precarious or insuffi-'cient income derived from voluntary contributions, their 'efficiency is to a great extent impaired and their develop-'ment cramped for want of funds. In some cases it is often 'impossible to maintain the number of patients for which 'the hospital building is adapted. Indeed the day may not 'improbably soon come when the falling off of the present 'casual support will necessitate the closing of a considerable 'part or the whole of some large institution, and bring 'misery upon the neighbourhood in which it is situated.' I am not disposed to dispute the force or the truth o the statement contained in the last sentence. Indeed, I believe we are within a measurable distance of its application unless the managers of the metropolitan hospitals can induce the public to take more genuine interest in their work and to extend to them a larger share of their pecuniary support.

The causes for the existing deficiency are not far to seek. The gradual migration of the wealthy classes from a district has often deprived the medical charities of that neighbourhood of much support upon which they previously depended. True as this is, it is still not a little remarkable to observe that the two general hospitals, viz., the St. George's and Westminster Hospitals, which occupy the finest sites of any charitable institutions in this metropolis, receive on the whole less support than probably any other institutions of their class. Thus whereas the voluntary income given to St. George's in 1873 was £15,449, it fell to £10,691 in 1881, and a total income of £22,236 in 1873 became £18,589 in 1881, although the income received from endowments and legacies was £1,100 greater in 1881 than in the former year. Again the voluntary income at the Westminster Hospital fell from £4,853 in 1873 to £2,993 in 1881; that derived from endowments and legacies from £12,525 in the former year to £3,648 in the latter, and the total income in 1873, viz., £17,867 became in 1881 but £7,152. On the other hand pay-patients are increasing at the latter institution, since their pay-

ments amounted to £511 in 1881, as against £489 in 1873. This is a small but gratifying increase in the right direction.

Thinking over the reasons for this falling off in income at the two institutions which of all others one would at first sight believe to be the best supported in the whole of London, I have been led to the conclusion that their prominent position has tended to do them more harm than good; that is to say, people observing the magnificent positions those hospitals respectively occupy, have said to themselves, 'what a noble charity! How well it must be supported, as its position brings it directly under the notice of the most wealthy classes of the community. For this reason it is not necessary for me to subscribe to it, as it surely cannot require help, and I shall therefore send my alms to one of the hospitals situated in some out-of-the-way thoroughfare of the metropolis.' Again, the migration of the artizan class to the suburbs has tended to emphasise the desire felt in many directions to have the hospitals brought nearer to the residences of the poor and to have them removed from the narrow area which they at present occupy. There can be no doubt that the success of provident dispensaries in some instances has been due to the feeling on the part of the working classes that the time they have to lose by attending the hospitals costs them more in the end than having a doctor brought to their own homes by means of the provident dispensary. This imperfect distribution of the hospital accommodation in the metropolis tends to injure the hospitals and to entail unnecessary hardship and suffering upon the patients. No doubt this cause for dissatisfaction may be met, in some measure at any rate, by combination amongst the various hospitals, with the view of securing that every suburb of London shall have its own hospital, so centrally placed as to render it easy for the poor of the district to seek relief without unnecessary loss of time. At the present moment a movement is on foot in Birmingham, which has originated with the desire of the largest general hospital in that town, the Birmingham General Hospital, to celebrate its centenary by the establishment of a chronic hospital in one of the suburbs.

There can be no question that the present centralization of the metropolitan hospitals tends to injure them directly and indirectly. Directly, by causing considerable dissatisfaction in the minds of the patients and of those who are interested in the patients owing to the long distances which many have

to travel, and to the consequent delay and difficulty in obtaining relief. Indirectly, because the majority of charitable people take no special interest in any particular hospital owing to the fact that it is not situated in their neighbourhood, that they seldom hear of it, and perhaps never see it, and in consequence they become year by year more disposed to distribute their alms amongst such institutions as come under their own immediate observation. This centralization of the metropolitan general hospitals makes many people believe that they are wealthy and largely endowed institutions which partake more of a public than of a private or charitable character, and which therefore do not need sustained support. I believe that in the present day, when charitable appeals have multiplied to such an extent that they amount to a positive burden, those charities, however deserving and well conducted, which fail to make their mark upon the minds and consciences of the people, must necessarily languish for want of funds.

Referring again to the tables I have given, let us see whether they afford any evidence of the causes which have contributed to create so large a deficiency as £28,000 in one year in the funds of nine large general hospitals. One cause is that small hospitals have become more and more aggressive, and that in consequence people who used to give only, and as a matter of course, to the large general hospitals, have come to distribute their alms amongst several special hospitals, as well as the general hospitals, which latter institutions consequently get but a fifth or perhaps a tenth portion of the support they used to receive from annual subscriptions and donations. There is no class of special hospital which arouses greater sympathy than a hospital for children. This is shown by the fact that the voluntary income of the eight children's hospitals has increased by 55·4 per cent. since 1873, the income derived from endowments and legacies by 106·3 per cent., and that from patients' payments by 42·9 per cent. Again, the amount of voluntary income received by the women's hospitals has increased by 15·4 per cent. in the period under consideration. Further, although the income from endowments and legacies received by the general hospitals has only increased by 8·7 per cent. in the last nine years, the income received from this source by the following groups of special hospitals has increased as under:—At the chest hospitals by 86·2 per cent.; at the lying-in hospitals by 77·7 per cent.; at the children's hospitals by 106·3 per cent.; at

the convalescent hospitals by 163·1 per cent.; and at the special hospitals by 44·6 per cent. This fact proves that special hospitals of all classes are becoming more popular and better known, and that they are consequently competing with the general hospitals for the support of the benevolent public, with increasing success every year. The need of convalescent hospitals has been greatly insisted upon during the last five years, and perhaps in some measure as a consequence of this fact, the increase in their income from endowments and legacies has been at the rate of no less than 163·1 per cent. during the last nine years. Again, the general hospitals have not at present recognised the desirability or importance of affording their patients an opportunity of contributing something, if they can afford it, towards the expense of maintaining them in the hospitals. This source of income has been assiduously cultivated by the special hospitals, and we find in consequence that the revenue they derive from this source has increased as follows:—Chest hospitals, 156·6 per cent., children's hospitals 42·9 per cent., convalescent hospitals 75·1 per cent., and special hospitals 75·0 per cent. The effect of the competition to which the general hospitals have been exposed during the last ten years is eloquently shown by the tables I have prepared.

The results which are likely to follow the ascertained and increasing deficiency of income as compared with an ever enlarging expenditure at the London hospitals have next to be considered. It cannot be doubted that one of two things must happen in the case of several of the metropolitan general hospitals. Either the committees of these institutions must bring their work more prominently before the public and adopt some different means of raising income, or more than one of these hospitals will have to be closed. Lest this statement may be thought an exaggeration, I will instance the case of one of the largest and best known of the London general hospitals, (which I may mention in passing is not the London Hospital) where during the last three years not only has nothing been invested, but capital to the extent of £8,230 in 1880, £1,328 in 1881, and £6,056 in 1882, has had to be sold to meet current expenditure. This represents a total loss of invested property during the three years of £15,614, or, taking the average, no less a sum than £5,205 every year. The total invested property of this institution at the present time is but £120,000, so that unless something is done immediately

there will, providing the present state of affairs continues, be no invested property to spend at the end of twenty years, and the hospital will have, therefore, to be closed. The financial straits of this great general hospital are even more serious than the figures I have quoted would make it appear, because in addition to the £15,614 invested property, the whole of the legacies received, amounting to £15,605, have also been expended during the three years under consideration. This is no solitary instance, but it must emphasise the truth of the statement that some of the most valuable general hospitals will have to be closed unless steps are taken to lessen the enormous and increasing deficiency which at present marks the difference between the available income and the necessary annual expenditure. Another and scarcely less serious result may be the closing of a great number of beds by a large number of the hospitals. This course has had to be adopted by two of the endowed hospitals, owing to the agricultural depression, one at present using only two-thirds of its available beds, and another having recently closed two hundred of those which had heretofore been maintained for the benefit of the suffering poor. Unfortunately, the mere closing of beds does not mean a large reduction in the expenditure. For instance, assuming it costs sixty pounds a-year to maintain a hospital bed, and the managers desire to lessen their annual expenditure by £6,000, they will not save £6,000 if they close one hundred beds, or anything like that sum, because the maintenance and the nursing of the patients constitutes relatively but a small proportion of the whole cost of maintaining a hospital.

What are the remedies which we may reasonably hope will bring about the necessary changes? I shall state these very briefly because my paper is already too long, and I hope that they will be brought out fully by others in the course of this Conference.

Of course the first cause of the present deficiency may be put down to the increase in the amount of work done each year by the metropolitan hospitals. As compared with nine years ago the London hospitals have maintained 17·7 per cent. more beds, and relieved 29·6 per cent. more in-patients. The greatest increase in the work done has been at the women's hospitals, where the beds have increased by 56·2 per cent., and the number of in-patients relieved by 104·9 per cent. Next in order came children's hospitals, with 55·9 per cent.

more beds, and 67·8 per cent. more in-patients; next chest hospitals, with an increase of 23·3 and 23·9 per cent. respectively, then convalescent institutions, with 23·1 per cent. and 47·3 per cent. respectively, then the general hospitals, with 14·9 per cent more beds, and 23·2 per cent. more patients, and finally special hospitals with 12·6 per cent. more beds and 25·6 per cent. more in-patients. This represents a large amount of additional relief afforded, and of course a much greater expenditure.

Further, all the metropolitan general hospitals must understand that if they are to succeed in maintaining their own against the competition of special hospitals they must adopt means to make the public familiar with their institutions, and with the amount of benefit which they confer upon the inhabitants of the districts to which they appeal for support. Heretofore it is quite certain that too little attention has been paid by the managers of general hospitals to the necessity for adopting a regular system of raising voluntary income. This will be evident when it is stated that the metropolitan general hospitals only received 42.3 per cent. of their whole income in the year 1881 from voluntary sources, whereas annual subscriptions and donations constituted 82·3 per cent. of the total income of all the children's hospitals, 81·7 per cent. of the total income of all the women's hospitals, 56·8 per cent. of all the chest hospitals, and 60.8 per cent of all the convalescent institutions. Again, I hope the day is not far distant when the managers of some of the larger general hospitals will come to the conclusion that in the interests of the poor, the time has arrived for them to dispose of the valuable sites upon which the hospital buildings are at present situated within that narrow area of one-and-a-half miles from Charing Cross, and that they will decide to take the hospitals to the densely populated neighbourhoods, and not continue to compel the sufferers as at present to come many weary miles, and to incur much avoidable and unnecessary expense. The Bill Mr. Childers has introduced and is now trying to pass through the House of Commons, entitled the "Cheap Trains Act," is but one of the many proofs forthcoming that if the managers of the majority of the London general hospitals determine to ignore the teaching of passing events and to remain together in one narrow area of this vast metropolis, first the funds will fall off, then new hospitals will be built and opened in the heart of those

districts where the people for whom hospitals were intended reside, and last of all the patients will decrease and cease to come the present long distances in search of the medical aid they require. This is sure to be one of the results of the present deficiency at the existing metropolitan hospitals, but it presents too wide a field of consequences to be followed out in this paper. I do not doubt that the recent determination to establish a central hospital in North London which was arrived at by the inhabitants of that district of their own accord on the grounds I have just stated, and which has resulted, as I am glad to see, in the determination of the authorities of the Great Northern Hospital to remove their hospital to the centre of the North district, and to amalgamate with the new scheme, is only the first instance of the new departure we may expect throughout the metropolitan area. Several of the existing general hospitals might change their site with profit and advantage, and I think on hygienic and public grounds a change of site in these cases is to be earnestly recommended.

Next, it is desirable that each general hospital should map out for itself a district to which it shall definitely appeal for support. That is to say, it is desirable that it should localise both the relief which it affords and the area from which it derives its income. If a general hospital cannot do this, it should prepare to move to a new district. If the London Hospital were, for instance, to turn its back once and for all upon the West of London and to determine to raise the bulk of its income in East London, I do not hesitate to state my belief that the million people who now inhabit East London are able to, and would certainly, contribute the additional £30,000 a year which is required. For instance, I myself believe that the employés of the port of London would contribute £15,000 a year, because I know that the employés of the port of Glasgow contribute at least £10,000 a year to the Glasgow hospitals. I further believe that a house-to-house collection every year throughout East London on the model of that adopted by the Edinburgh Infirmary, the introduction of a system encouraging the in-patients to contribute according to their means for their support during their stay in the hospital, and a collection throughout the workshops of East London, on the system so successfully carried out by the authorities of the North Staffordshire Infirmary, would produce more than the £30,000 a year required. Of course this system means a considerable

amount of labour and trouble in the early stages, but it cannot fail to be successful, and knowing this, I venture to advocate its adoption by the authorities of that great charity. To re-arrange the system of financing and distributing relief at the metropolitan general hospitals is no doubt a serious undertaking, but a re-arrangement has become absolutely necessary, and the sooner it is undertaken the sooner will it be accomplished.

Lastly, I am convinced that a Royal Commission of inquiry should be appointed to impartially collect evidence to elicit the actual facts. This point will be dealt with by others, and I need not therefore do more than allude to it incidentally here.

No one who has given any thought to this matter will fail to admit that something must be done, and I am one of those who feel that that something is not to give up in despair, not to memorialise Parliament and the Government of the day to institute a hospital rate, but on the contrary to recognise that in the past the metropolitan general hospitals have been brought too little under the notice of the philanthropic public, and that if an alteration of system be adopted, it will remedy this and attract the sympathy of the individuals who directly or indirectly benefit in the work of these institutions, and who ought to take a warm interest in their prosperity and good management. That is the best and right method, and the one which the managers of every metropolitan hospital ought to endeavour to introduce in connection with their institution. It is to be done by localising the area from which each hospital draws subscriptions, and emphasising the work that it does for the inhabitants of that area until each individual who resides within it, and who is capable of giving something to the hospital, does contribute that something. In this way the funds of these noble charities would be made adequate to the claims which the suffering poor must for all time make upon their resources.

Table showing Number of Beds, In and Out-Patients, Management Expenses, Income and Total Expenditure of the several Metropolitan Hospitals arranged in Groups.

CLASS OF HOSPITAL.		No. of Beds.	In Patients.	Out Patients.	MANAGEMENT. Salaries.	MANAGEMENT. Advertising, Printing, Stationery, Postage, Law, and Incidentals.	MANAGEMENT. Total Management	INCOME. Voluntary Income.	INCOME. Endowments and Legacies.	INCOME. Patients' Payments.	INCOME. Total Income.	Total Expenditure.
					£	£	£	£	£	£	£	£
16 General Hospitals -	1881	3,109	31,692	321,450	9,359	8,251	17,610	93,080*	117,439	1,370	220,070	215,569
	1873	2,707	25,727	335,631	7,563	5,578	13,141	95,725	108,029	1,592	205,752	175,876
5 Chest Hospitals -	1881	545	2,768	35,222	2,519	2,432	4,951	28,664	19,740	2,094	50,498	59,854
	1873	442	2,234	38,452	1,942	2,295	4,237	31,592	10,602	816	43,010	40,014
4 Lying-in Hospitals -	1881	128	1,416	2,998	570	487	1,057	3,567	7,107	9	10,683	11,874
	1873	147	1,337	2,485	406	234	640	4,270	4,000	—	8,267	7,179
8 Children's Hospitals -	1881	594	4,052	45,500	1,736	2,382	4,118	33,927	5,371	1,938	41,236	34 048
	1873	381	2,415	57,422	957	1,752	2,709	21,830	2,603	1,356	27,733	30,752
5 Women's Hospitals -	1881	203	1,744	19,742	878	1,177	2,055	13,678	1,184	1,885	16,747	15,434
	1873	130	851	20,748	937	1,182	2,119	11,855	3,168	1,849	16,872	12,839
7 Convalescent Hospitals,	1881	868	8,443	—	896	696	1,592	10,855	3,310	3,702	17,867	17,526
	1873	705	5,730	—	696	490	1,186	11,109	1,258	2,114	14,481	14.479
19 Special Hospitals -	1881	843	5,405	104,610	3,976	3,764	7,740	26,663	24,508	6,181	57,352	44,491
	1873	749	4,305	88,754	3,395	3,088	6,483	45,339	16,944	3,531	65,812	43,372
3 Institutions - -	1881	298	953	42	534	654	1,188	5,024	6,848	3,257	15,129	12,973
	1873	337	966	50	423	462	885	5,290	3,454	3,974	12,728	13,784
67												
67 Total Year	1881	6,588	56,473	530,564	20,468	19,843	40,311	215,058	185,507	20,436	429,582	411,767
,, ,,	1873	5,598	43.565	543,542	16,319	15,081	31,400	227,010	150,058	15,232	394,655	338,295

* Less £10,181, being Extraordinary Income. † Less £22,500, being a legacy specially left for building and current Expenditure.

Discussion.

Mr. Bousfield said there was no doubt that the existence of the problem now under discussion was the real reason why the Conference was held. If the funds had not been falling off there would not have been a desire to reconsider the whole question of hospital management. It was on this account that a plan must be devised of dealing comprehensively with the medical institutions of London. At present they were quite disorganised. Persons looked at the question from a variety of stand points; some from the purely charitable and philanthropic; the medical profession from the point of view of the medical school; some with reference to the Hospital Sunday Fund; and some from the working class point of view as represented by the provident dispensaries and the Hospital Saturday Fund. There was also the poor-law point of view which was represented by the great infirmaries. All were treating one question in totally different ways, without system, and in a purely temporary manner. The present system of poor-law infirmaries was only a temporary one. There were great hospitals scattered over London, supported by the rates, dealing in a large degree with the class of cases dealt with in hospitals. He had watched the way in which cases were admitted in the poor-law infirmary at Kensington; roughly speaking, three fourths of them came indirectly without passing through the workhouse and returned direct to their homes; and these would go to a hospital if one existed in Kensington. The guardians had little power of checking the admission of patients. The infirmaries were gradually becoming great hospitals attempting to deal with the sick of their localities. They only required medical schools attached to them to make them like general hospitals. They were being gradually improved in nursing and in many ways. Would the charitable public, when they found that these infirmaries were treating poor cases as well as pauper cases subscribe to the voluntary hospitals of London? There certainly would be great danger of their refusing to do so. As the voluntary schools were suffering in competition with the board schools, so would the voluntary hospitals suffer in competition with the poor-law infirmaries. Up to the present the fever and small-pox hospitals of the Metropolitan Asylums Board had been poor-law hospitals supported by the rates; a Royal Commission had recommended they should no longer be poor-law institutions; and it was only a step further to apply the same principle to the poor-law infirmaries. These poor-law infirmaries had more in-patients than had the voluntary hospitals, and the best of them were dealing in quite an effective way with the mass of sickness requiring clinical treatment. No doubt the obtaining of funds for the hospitals was complicated by the exist-

ence of medical schools; some would seem not to have been founded originally with the main objects of forming philanthropic institutions, but specially to enable medical schools to be conducted, such as King's College Hospital and University College Hospital. In considering the future of these and of all hospitals we could not lose sight of the medical schools. Their existence was one of the great difficulties that stood in the way of localising the hospitals of the metropolis. Where there were medical schools they would require to have hospitals attached to them. There was no doubt that, while medical schools brought a certain amount of support, the efforts of medical men brought donations and legacies to hospitals; at the same time the schools involved very considerable expenses, which had to be paid out of money subscribed for charitable purposes. This was not likely to be continued. It would be necessary to discriminate and to divide the expenses which were incurred for the medical schools from those which were incurred for the reception of sick patients. The cost of a medical education was now so great, that the students could not be expected to pay more than they at present did, as a subsidy to the hospitals; but it was the public interest that the medical schools of the hospitals should turn out numbers of well trained medical men; and he looked forward to a payment from the State to the hospital for each student trained equivalent to the expenses which the medical school put the hospital to in teaching the student. It had been said that patients were exposed to hardship in having to go from one part of London to another. He had watched their gravitation to various hospitals, and he found there was no principle whatever in the way they were chosen. It often happened at King's College Hospital that there was a large number of patients from the immediate neighbourhood of Guy's. At St. Bartholomew's a great number came from the immediate neighbourhood of the London Hospital. There was a great deal of caprice which led to patients choosing hospitals far distant from their homes. As long as they were allowed to chose he did not think that the principle of localisation had much weight.

Mr. G. A. Cross (London Homœopathic Hospital) asked for some explanations of the statistics in Mr. Burdett's paper, and said that it was fallacious to treat as current income legacies which were invested as in some cases they were compelled to be. The deficiency of £40,000 at nine institutions mainly arose, he believed, from the deficiency at three or four institutions, so that if they were left out of the account the returns were not quite so unfavourable for the others, especially when some met their expenditure and had balances. The Homœopathic Hospital paid its way, and sometimes had a few pounds over at the end of the year: legacies were invested, according to a law of the hospital,

but of course they appeared in the annual published accounts. When it was said that auditors sometimes suppressed capital accounts, was it simply that the capital accounts were not printed but could be seen by anyone asking for them? Reasons ought to be given why particular years had been chosen for some of the returns in the paper, for there might be, in those years, qualifying circumstances, and the intervening years might materially affect a statement of increase or decrease for a series of years. A most valuable part of the paper was that in which it was urged that it was a great mistake, though it was one often made, to diminish the number of patients with the view of diminishing the expenditure. The salaries, wages, rates, repairs, firing and lighting, and the main proportion of the maintenance expenses, went on all the same, and while the expenditure was slightly reduced, the cost of each patient was made excessive.

Mr. Thomas Ryan (Queen Charlotte's Hospital) said that in connection with the subject of hospital finance there was one very important point to which he desired to call attention, namely, the necessity for adopting a uniform system of keeping hospital accounts. In any inquiry whatever, the first essential was a clear statement of the existing condition of things, and when the subject under discussion consisted of several sub-divisions, as in this case, it was absolutely necessary that the data supplied by each should not only be full and accurate, but should be presented in a uniform shape so as to admit of ready and just comparison. He had never read a book on hospital administration in which the necessity of this reform was not referred to. Nor was this to be wondered at, for at the present scarcely two hospitals prepared their accounts in the same form, as everyone who had studied hospital management, and had therefore occasion to refer to the reports, had found to his cost. The subject had, however, so far, not been dwelt upon at this Conference, and he therefore ventured to refer to it, and to insist on its importance. He might also be permitted to suggest that if the Council of the Association under whose auspices the Conference was held, or a committee appointed by them, would draw up a form of accounts and submit the draft to the committees of the several hospitals for suggestions, and then prepare a final form embodying these suggestions, they might invite the various committees to undertake that the accounts of their institutions should be printed in that form in the annual report. He was of opinion that the majority would be glad to co-operate with this view, and that much good would thus be effected.

Dr. Tibbitts (Bradford Infirmary) said that the question of finance was one of the most important. All the patients, except

the really very poor, should be made to give some contribution to the hospital, however slight it might be. Either provident dispensaries must arise in the large towns, or the poor must contribute something to the hospitals. But there were evils connected with dispensaries. In the case of one in a country district with a population of 8,000, of 2,000 members 1,500 applied for medical relief within the year, often not because they wanted it, but because they were members. They said, "We are in the dispensary and we might as well have the benefit, &c." Persons like butlers, coachmen and others, who had been in the habit of paying £5 or £10 a year to a medical man, joined the dispensary, and paid 1d. a week, or 4s. 4d. a year for all the medical aid they required. In another case, the three medical men attached to the dispensary kept assistants, and did their work by proxy. In this way there was a great danger of the work being done in a slovenly and inefficient manner. At the Bradford Infirmary the secretary was instructed to inquire carefully but courteously into the financial position of the patients, and the result was that in the course of the year about a hundred patients were sent away as unfit objects of the charity. Formerly a large millowner would engage a medical man to attend to those employed in the mill, and if an employé met with an accident he was attended to by the medical man, who was paid for his services. But now many of the millowners, doubtless quite unconscious of the difference it made, paid a few guineas per annum, and no matter what happened to their employés, they were taken off to the hospital. Then the employer obtained for the three or six guineas medical relief for his workpeople, which formerly might have cost from £50 to £100. Cases of this kind required to be taken up earnestly, as many employers, if the matter were put before them, would willingly contribute something more to defray the heavy expenses of these very serious cases.

Mr. Henry C. Burdett, in reply, said that Mr. Bousfield had misapprehended the work of the poor-law infirmaries and the position they occupied. They were for paupers; *i.e.*, for those who were chargeable on the rates, and anyone familiar with the poor-law infirmaries of the metropolis would know that as to buildings they were probably if anything more complete than the voluntary hospitals. As to patients the poor-law infirmaries had to take in the very refuse of the population as well as the unfortunate poor, and for that reason it would be nothing short of cruelty to say that the respectable poor should have no other hospital refuge in the hour of sickness than the poor-law infirmary. The necessity for medical schools need not necessarily prevent the localisation of metropolitan hospitals. There was a growing feeling among the medical profession that students

would be best trained at a central school at which professors should devote their whole time to the subjects they taught. The difficulty at present was that there was no means of remunerating professors except by the fees of the students, and the teachers had to depend for part of their income upon private practice. It was admitted to be desirable that certain branches of medical education, like anatomy and physiology, should be taught by specialists devoting their whole time to them. In reply to questions he exhibited a volume of details which could not be embodied in the paper, but which was open to examination by anyone desiring to examine into the facts on which the tables attached to it were based. One reason for fixing upon 1873 was that that was the year in which the metropolitan hospitals began to suffer, and another was that it marked the commencement of the Hospital Sunday Fund. From that time their management had attracted increased attention and on the whole it had exhibited a certain degree of improvement. The legacies he had referred to were not invested. Hospitals had to spend capital in order to meet deficiencies of income. He was well aware that the rules of many hospitals prevented the investment of legacies, and for that reason he had shown that whereas nominally there was only a deficiency of £40,000 in the income of the London hospitals, yet in reality, if you treated as income what was properly income there was an excess of expenditure over income which approached to £120,000 a year. Even in the case of the six hospitals taken from the nine there was a substantial deficiency. In selecting years to show how invested property varied, he began with 1868, then passed to 1876, an interval of eight years, and then to 1882. The last six years shewed that London hospitals were not receiving as much support as they required and used to receive—he referred especially to the large general hospitals. The abuses attaching to certain institutions did an enormous amount of harm and injustice to the best managed hospitals, because the public did not know which was the best managed and which was the worst. He therefore desired that there should be an independent inquiry, that the really deserving hospitals should be known, and the people should be free to give liberally with confidence. Inquiry would also elucidate the question whether certain institutions were well placed, or whether a redistribution of the capital they possessed might be made with advantage to the community at large. It would be an enormous advantage if the distributors of the Hospital Sunday Fund would say that the accounts of the hospitals receiving benefit must be kept upon a certain uniform plan, for it would be no more trouble to keep them on one plan than on another. At a conference of hospital chairmen the thing might be settled in an afternoon;

and it would satisfy the charitable public and benefit the hospitals. In his paper he wished simply to emphasise the fact that the professional auditor was not a panacea, because it had happened that he had suppressed the evidence on the capital account, and had only restored it when its absence had been pointed out to the committee.

IX.—*The Difference between the Systems for raising Income and Controlling Expenditure at the Metropolitan and Provincial General and Special Hospitals. By* THOMAS BLAIR, *General Manager, General Infirmary, Leeds.*

Hospital administration, and especially the financial portion, is undoubtedly one of the greatest social and public questions of the day.

As sound finance is the source or mainspring from and by which all the varied working machinery of medical charity derives life and sustenance, it must be obvious even to the most casual observer that its importance cannot be too highly estimated, and that its organisation and adjustment demand the most skilled and experienced workers.

Provincial hospitals generally have an executive committee, which at some institutions is styled finance, at others, house committee.

The members of this committee are specially selected from the weekly board because of their well-known aptitude for business and their capacity for organisation.

An executive committee consisting of five or six good practical business men, possessing a thorough knowledge of the hospital and its requirements, with a determination that no amount of labour on their part shall be lacking to make the institution a success, is vastly superior to the far too often inert and spiritless committee of twenty or thirty people, whose names appear formidable and useful on paper, but whose faces are seldom, if indeed ever, seen within the four walls of the board room.

But it is argued by many people that such names serve a great purpose, they are made to play an important part in

hospital administration, for not only do they add a tone of security and dignity, but the family influence or official position is found to be of incalculable service in raising funds in times of pressing need.

While hospital managers are deeply sensible of the inestimable value of personal influence, whether it be of a social or official character, and while it is very desirable to connect the names of persons, eminent in social, philanthropic, and scientific circles, as closely as possible with hospital management, yet it is obvious that their proper function is not fulfilled in serving on active committees, such as finance committees unless they possess the necessary qualifications. They should rather be used as a sort of external auxiliary power, ready at hand to perform a special service.

The principal functions of an executive committee are:—

1.—To raise the necessary income.

2.—To control the expenditure.

As regards the first point it may be assumed that the majority of the metropolitan and provincial hospitals derive most of their income from a similar source, viz., subscriptions and donations, though the systems for obtaining such probably differ.

The provincial hospitals derive their income from various sources, which may be divided into two classes, the reliable, and the unreliable. Under the head of reliable income are placed:—

1.—Interest, dividends, and rents accruing from investments.

2.—Annual subscriptions, which may be classified as follows:

(*a.*) Subscriptions from manufacturers, merchants, shopkeepers, railway and canal companies, collieries, and so forth.

(*b.*) Subscriptions from workpeople in mills, workshops, collieries, dockyards, and other places of industry, or through the means of Hospital Saturday.

(*c.*) Subscriptions from friendly societies.

3.—Hospital Sunday collections.

Annual Subscriptions.—Provincial hospitals are considered to be in a very unhealthy state of finance if they continue with a small annual subscription list, for this class of income is looked upon as the most important of any, and consequently every effort is put forth to cultivate and develop it to its utmost limits. In this the authorities of the metropolitan

hospitals differ, for they appear to rely more upon spasmodic efforts to obtain donations to relieve their pressing necessities, and to carry them on for a certain given period, rather than to seek to establish themselves upon a firm and lasting basis by augmenting their annual subscription list year by year.

The provincial hospitals very rarely advertise for money. Their plan is to employ a collector who devotes the whole of his time to the work, and being usually remunerated by salary and a commission on sums exceeding a fixed amount, it follows that he exercises his utmost endeavours to increase the income. At a certain period of the year he prepares a statement for the committee, giving the names of those subscribers who decline to continue, and of those who have notified their intention to decrease, their subscriptions. The names of the defecting subscribers are usually distributed amongst the members of the committee who either, by a personal visit or by letter, urge the necessity of their continued support. These efforts are mostly successful, and frequently the same plan is adopted to induce others to increase their subscriptions. This system has numerous and varied advantages, but these are too extensive to enter into in this paper.

Under the head of unreliable income are placed:

1.—Donations.

2.—Legacies.

Both of these are ever acceptable, but being of a precarious nature it is considered safer to exclude them in estimating the annual income.

In addition to these, at some hospitals considerable sums are received yearly from a miscellaneous source, such for instance as proceeds of cricket and football matches, musical entertainments and the like. From this source alone the Leeds General Infirmary received last year about £900.

Again, the officers of local branches of Friendly Societies in rural districts from which patients are received are utilised by arousing in them a personal interest in hospital work. Their mode of action is this. The Friendly Societies of the parish or district amalgamate and organise a gathering on a set day. They march in procession to church or chapel, when a sermon is preached and a collection made. During the progress to and from church a number of men carry collecting boxes to receive casual donations. Also, concerts and musical festivals are promoted,

frequently by the same people, and are held in the open air when the weather permits. No anxiety of any kind falls upon the hospital, for the working men themselves undertake all the labour and responsibility of the demonstrations. From this source the Leeds General Infirmary received last year nearly £200.

Movements of this kind ought to be encouraged everywhere as much as possible, for wherever this principle of self-help exists thrift and independence of character will also be manifested, with the result that larger and more regular contributions will be received from those immediately benefited by the medical charities.

Workpeople's Subscriptions and Donations.—To this source of income special attention is given in the provinces. Its collection requires a good deal of patient, self-denying labour as well as skill and discretion. The British workman as a rule will not contribute much to a hospital until he is thoroughly convinced that he will receive his *quid pro quo.* The system adopted to obtain the support of the working classes varies to some little extent in different towns owing to local peculiarities. What has been done at Leeds is this: the collector has appealed to the large employers of labour in mills and workshops to grant him facilities to speak to the people on the premises. They have readily consented to stop the machinery a little earlier for dinner. He has then gathered the people together and shown them in a few words what the infirmary was doing for them, and was still willing to do, and in return for the great benefits received by them it was only just on their part that they should do something for the infirmary. Afterwards he would see the managers and foremen of departments, for unless their sympathies were won, and they were willing to take the matter up, all the collector's persuasiveness might avail nothing. However, this mode of action has seldom failed. Some of the people have consented to leave in the pay office ½d. to 1d. weekly; others have agreed to work a quarter of a day overtime once a quarter, and in some establishments the people are engaged upon the understanding that ½d. or 1d. will be deducted from their wages weekly for the infirmary. In this way the Leeds General Infirmary received last year £2,018.

The following are some of the largest provincial hospitals with the amounts contributed by the working classes last year: Birmingham General, £1,983; Birmingham Queen's,

£931; Bristol Royal, £893; Hull General, £874; Leeds General, £3,308; Leicester, £1,599; Edinburgh Royal, £745; Glasgow Royal, £5,352; Glasgow Western, £2,735. The London Hospital, which boasts of having the largest number of beds in Great Britain, received only £1,882, the collection of which cost £203.

The annual subscription list of the provincial hospitals just quoted ranges from £2,000 at the smallest, to £10,800 at the largest institution: whereas at the London Hospital it amounts to only £2,405. These are facts which speak for themselves.

At the majority of the provincial hospitals there still exists as a means of raising income the recommendation system. Certain privileges are granted for subscriptions of one to five guineas, and in the case of donors qualifying as life governors, from ten to fifty guineas in one or two sums. But there are also a fewhospitals which are practically free institutions, where the only recommendation required for admission is that the applicant should be suffering from disease or accident.

There is one most objectionable mode of deception resorted to for raising funds, and it applies more particularly to those institutions styled *special hospitals*, viz., that system of registering the same individual patient every 4, 6, or 8 weeks, and appealing to the benevolent public for increased support on the strength of the seemingly large number of patients having passed through their institution.

At some of the provincial hospitals subscribers are required to contribute towards the maintenance of their domestic servants while under hospital treatment, usually at the rate of 7s. 6d. to 10s. 6d. per week. Also, when able, the in-patients are expected to contribute towards their maintenance, and the cost of surgical appliances. Inquiries are instituted into the circumstances of those who appear fairly well able to do so, through the agency of the Charity Organization Society, and other kindred associations; by this means a vast amount of deception and misapplication of charity is prevented, and the people preserved from the demoralising effects of pauperising themselves. At some provincial hospitals upwards of £400 a year is received in small sums for maintenance and surgical appliances.

Controlling Expenditure.—If it were possible this aspect of the subject is even of greater importance than that of

raising funds, for here will be manifested the practical utility of an executive committee composed of thorough business men, fully competent to grasp working details, and willing to see them carried to a successful issue.

One of the special functions of a finance committee is to make the income go as far as possible, having at the same time due regard to efficiency in every department of the hospital.

In the provinces, legacies and donations of certain amounts, according to the income of the hospital, are invested as a permanent endowment fund, the interest only being available for maintenance. The minimum fixed varies from £50 to £500.

At most provincial hospitals articles of consumption, including drugs, and the maintenance of the fabric are contracted for, the result being a considerable saving.

At some institutions the accounts are laid before the finance committee for payment monthly, at others quarterly, and the usual mode of payment is by cheque.

At some hospitals it is part of the duty of the secretary or superintendent to assist in controlling the expenditure. For example, all orders to tradespeople and others are issued through him, and all bills are checked and certified by him. Surgical appliances are ordered through him, to whom the patients are required to pay the whole or a portion of the cost if able. He is also expected to see that those patients whose circumstances will permit contribute something towards their maintenance.

Some hospitals give away indiscriminately surgical appliances at the rate of £600 a year, which is equal to the annual interest of £15,000 at 4 per cent. without making the least effort to obtain some portion from the patients.

These may appear trifling details and unworthy of the attention of a great hospital in which the total of these items forms but a small amount of the expenditure, but whenever the small details of expenditure are well looked after it is quite certain that the large items will not escape observation, and that in the aggregate a considerable saving will be the result.

The provincial public are of opinion that medical charities are unworthy of their support which permit debts to accumulate year after year, for as certain as bankruptcy will overtake a merchant in such a condition, so with equal certainty will financial difficulty overtake a charity.

Executive committees also consider that they have no right to contract pecuniary obligations knowing that the probable income will be totally inadequate to meet the just demands thus created.

It certainly is no justification to argue that the mass of suffering and disease around them must be relieved. They recognise this important fact, that it is their function to see that the expenditure does not exceed the income to any appreciable extent.

Hospitals managed on the principles indicated by this paper are certain to be useful institutions, and are not likely to suffer from the painful apprehension of financial embarrassment.

X.—*A Few Notes on the Raising of Income, and the Control of Expenditure, in Provincial and other Hospitals. By* R. HORDLEY, *Secretary and House Steward, North Staffordshire Infirmary.*

The question of providing the ways and means on the one hand, and a sufficient supervision and control over the expenditure on the other, is one that has ever been a source of anxiety in all well regulated hospitals, and any suggestions for assisting the managers of those institutions in carrying out these objects are worthy of consideration.

The income for the support of such institutions may, as a rule, be divided into the following classes, viz.:—

1. Private annual subscriptions.
2. Weekly contributions from workpeople.
3. Annual collections in places of public worship.
4. Annual collections from workpeople and others in manufactories, &c.
5. Miscellaneous contributions.
6. Donations and legacies.
7. Income derived from endowments.

The income from classes 6 and 7, of course, depends very much upon the wealth of the residents in the locality in which the institution is situated, and the amount of sympathy felt towards the objects it is intended to promote.

Private subscriptions, as a rule, are obtained by canvassing for them, either personally or by circular, and to do this

effectually, it is advisable that the county or locality should be divided into districts, and stewards appointed, with a chairman (or convener) for each district, to solicit subscriptions and collections.

It is of great importance that these offices should be faithfully and efficiently fulfilled, as the changes of circumstances, and of residence, in the subscribers, can only be known intimately by residents in the neighbourhood.

It is also desirable to keep a record of the "accident" and "urgent" cases admitted as in or out-patients, so that when they come from the establishments or workshops of non-subscribers, application may be made for subscriptions, or for "Hospital Saturday" contributions.

In some provincial hospitals, an important item in the annual income is derived from payments made by work-people at manufactories and other places where they may be employed.

These are most productive where they are paid weekly or fortnightly, and taken charge of by the cashier or clerk who has the payment of wages, and handed over to the hospitals quarterly, half-yearly, or annually as may be most convenient.

In one of these hospitals, established in the first place, in 1804, as a dispensary and house of recovery, the managers, on proposing some ten years afterwards to erect a suitable building for an infirmary on what was at that time considered an eligible site, made an appeal to the working classes for their willing, zealous, and steady aid in meeting the great increase in the expense which must necessarily be incurred in carrying out the project.

To regulate the weekly subscriptions which they solicited for that purpose, the following rules were drawn out, viz.:—

(*a*) An establishment subscription shall be considered a joint subscription of the persons contributing the same, in the manufactory or other establishment from which it is paid, and shall entitle them, as a body, to the privileges specified in statute (*e*).

(*b*) Establishment subscribers shall contribute during every working week according to the following scale, viz.: Each person who earns upwards of eighteen shillings per week shall contribute not less than one penny weekly; each person who earns upwards of seven shillings per week, shall contribute not less than one-halfpenny weekly; and each person who earns

not more than seven shillings per week, shall contribute not less than one farthing weekly.

(*c*) Persons who are subscribers, their children, and step-children, under fourteen years of age, and wives (not employed in manufactories or collieries) may alone be recommended as patients, by virtue of an establishment subscription.

(*d*) The master of an establishment which subscribes may either himself vote and recommend patients in his name, or address to the secretary a certificate containing the name of the person who is alone to exercise those privileges, which name shall be registered by the secretary; and only one vote shall be allowed on behalf of each establishment.

(*e*) The scale of privileges in recommending patients shall be as follows:—

Annual Subscription.	Out-Patients on the Books at one time,	In-Patients in the course of the year.
£ s. d.		
1 1 0	1	0
2 2 0	1	1
3 3 0	2	1
4 4 0	2	2
5 5 0	3	2
6 6 0	3	3

And so on according to this scale.

The amounts received from private and establishment subscriptions since that time, up to the year 1882 inclusive, have been as under, viz.:—

	Private Subscriptions Per Annum.	Establishment Subscriptions Per Annum.
Average of 6 years to 1822	£679	£277
,, 10 years to 1832	£737	£392
,, 10 years to 1842	£864	£623
,, 10 years to 1852	£940	£906
,, 10 years to 1862	£1,102	£1,717
,, 10 years to 1872	£1,567	£2,249
,, 10 years to 1882	£2,279	£2,736

The total amount received from those sources was,

From private subscriptions	£79,006
From establishment ditto	£87,928

During the year 1881, the amount received from these two classes of subscribers was,

From private subscribers	£2,175
From establishment ditto	£3,085

and the cost of patients recommended during the year by virtue of their payments, was as under, viz. :—

Patients recommended by Private Subscribers.	Patients recommended by Establishment Subscribers.
£2,698	£2,718
Being a loss of £523.	Being a profit £367.

The income realized from annual collections at places of public worship, and in manufactories, workshops, and other places, has attained to considerable importance during the past ten or fifteen years.

On comparing the financial statement of fifteen provincial hospitals for a recent year, it appears that the Hospital Sunday and Hospital Saturday collections average nearly one eighth of the total income.

This source of revenue is particularly valuable, being at once a direct benefit to the institution receiving it, and a stimulus to the benevolent feeling in the neighbourhood.

To control, effectively, the expenditure in an infirmary or hospital, it appears to be absolutely necessary that the managers should have a regular and detailed statement every month of the cost per head per day, so that any increase in the same can at once be ascertained, and explanations requested.

The following table, in use at a modern provincial hospital (built on the pavilion principle), from which the particulars as to subscriptions were taken, appears to answer the purpose for which it was drawn out. The statement is placed before the weekly board the first week in every month.

COMPARATIVE COST PER HEAD PER DAY.

MONTH.	YEAR.			
APRIL.	1883.	1882.	1881.	1880.
Number of Weeks in Month...	4	4	4	5
Average Daily Number				
Of Patients	178	164	159	158
Of Establishment ...	62	58	58	60
Total ...	240	222	217	218
Cost per head per day ...	12·01d.	11·34d.	11·77d.	13·02d.

Cost per head per day, in under-mentioned Items.

	d.	d.	d.	d.
Bread, Flour, and Meal ...	1·22	1·28	·97	1·26
Milk	1·08	1·08	1·15	1·06
Groceries...	·72	·74	·73	·85
Cheese and Butter... ...	1·32	1·36	1·24	1·16
Butcher's Meat	5·44	5·06	5·06	5·22
Potatoes and Vegetables ...	·40	·14	·22	·41
Eggs	·12	·05	·13	·20
Beer, Ale, and Porter ...	·34	·43	·52	·77
Wines and Spirits	·26	·16	·44	·52
Soap and Candles	·32	·35	·35	·36
Fish and Poultry	·35	·30	·61	·76
Gas	·44	·39	·35	·45
	12·01	11·34	11·77	13·02

Quantities ordered for Patients.

Eggs (number)	354	203	626	709
Ale and Porter (pints) ...	150	107	312	211
Wines and Spirits (oz.) ...	1152	735	2201	3493
Beef Teas (pints)	1190	1262	1302	1601
Fish and Poultry (diets) ...	288	136	431	819
Chops	175	60	130	142

This table shows the average number of patients and establishment (or household) per day, during the month; the average cost per head per day, patients and establishment, during the month, in housekeeping and gas; with the average, for the same month, in three preceding years. Also, the average cost per head per day in the following classified items of consumption, so that in the event of increase, inquiries can be made, and explanations given by the house steward, viz. :—

In Bread, Flour, and Meat,
„ Milk,
„ Groceries,
„ Cheese and Butter,
„ Butcher's Meat,
„ Potatoes and Vegetables,
„ Eggs,
„ Beer, Ale, and Porter,
„ Wines and Spirits,
„ Soap and Candles,
„ Fish and Poultry,
„ Gas.

The statement also shows the quantities of the following

items, ordered by the medical officers during the month, for the patients, as distinguished from the household, viz. :—

Eggs (number)
Ale and Porter (pints)
Wines and Spirits (ounces)
Beef Teas (pints)
Fish and Poultry (diets)
Chops (number)

An account is kept of the stimulants (ale, beer, and porter) supplied to the household, and no stimulants are given to workmen occasionally employed on the premises. Provisions, &c., as a rule, are obtained by contract. Under this system, no great increase can occur in the expenditure on housekeeping without the knowledge of the managing committee.

The expenditure in the dispensary department is under the control of the medical board. The regulations are as follows :—

Lists of the drugs, &c., required from time to time, are submitted by the dispenser and the senior resident medical officer to the medical board, and, on their approval, the orders are signed by the senior resident medical officer.

Delivery notes, with full particulars of the goods, are required at the time of delivery from each firm supplying them.

The dispenser receives all goods, and vouches for their correctness.

The order books, delivery notes, and invoices, (or statements) are then handed to the secretary, who prepares them for the auditors.

When practicable, alterations to and repairs of buildings, and additions to furniture, are executed by contract.

In the case of workmen being otherwise employed, a time book is kept, showing every Saturday the number of hours made by each workman, and the quantities of the materials used. This book is placed before the weekly board at their next meeting.

These methods seem calculated to answer the purpose of controlling the expenditure, or, at all events, of fixing the responsibility for it when it is found to be excessive.

Discussion.

Mr. Rowland Hamilton said that in former discussions it had been interesting to compare the observations of those working in the country, and of those working in the metropolis; and he regretted that on this special question the Conference had not heard more particulars about the large London hospitals. The last paper suggested how large an amount of intelligent personal interest should be brought to bear by those who were managing even a comparatively small hospital. The system of audit was, no doubt, a most essential matter, but, without disparagement to professional accountants, he would venture to say that far too much was often expected of them. After all they could do nothing more than deal with facts and figures as laid before them. They could certify that the accounts submitted were duly vouched and correctly abstracted from the books of the institution. That no doubt was necessary, but it was far from all that ought to be done to enable those concerned in a hospital to understand its position and affairs. Accounts might be considered from two points of view. That the cash accounts should be duly verified was obvious to all. But it was also important that accounts should be so kept as to shew how the expenditure was going on from day to day, was being duly apportioned to the various objects of the institution. The plan adopted in the paymaster's office, and in other large institutions, was well worthy of consideration. The check upon cash payments was prompt and immediate, but the accounts, under their appropriate headings, were further summarised periodically, say from month to month. Such a summary placed before the managers gave them an insight into and a control over expenditure which it was difficult, or almost impossible, for them to exercise if only the large aggregate of incongruous items were submitted to them. Moreover a reference to any special facts was far more easy and certain when accounts were thus intelligently summarised. Owing to the vastness of London there was great difficulty in exciting an interest in local affairs, and an unanswerable argument against the localisation of endowments was furnished by the tendency of the population in this and other large towns to leave the centre for the outskirts. If endowments were left to the poor they should follow the poor, and not be tied down to the locality which they had deserted.

Sir William Wheelhouse, Q.C., said that in Ireland hospitals and dispensaries were exempted from local rates, and in England, notwithstanding the dislike of exemptions, scientific institutions

escaped. The reason for the exemption was that the locality obtained a benefit more than equivalent to the sacrifice it made, and the view would be still more justified in the case of a hospital. He was quite satisfied that there was not sufficient examination into the pecuniary means of those who took advantage of hospitals. Such examination could scarcely be too close, for it was only reasonable, except in accident cases, that those who could afford to pay should pay something, however small. He was connected with a hospital for children, and for every inmate 4s. 6d. a week had to be paid, the difference between that sum and the cost being met by subscription. Somehow in the case of the neediest the money was found for the necessary payment. Sometimes there was scarcely sufficient control of daily expenditure, and this could be usefully checked by a fortnightly or monthly comparison of different items and inquiry into the causes of increase or decrease.

Mr. G. B. Lloyd (General Hospital, Birmingham) said that, without at all withdrawing what he had said yesterday, that sooner or later hospitals must come under public management and be supported by rates, like asylums and elementary schools, for the reason that charity did not accomplish much more than half the work requiring to be done for in-patients, he might still admit that for the lifetime of many who were present things must go on as they were. The difficulty in London seemed to be a lack of popular interest in institutions which did not appear to have a sufficiently democratic basis. Mr. Blair's paper was useful as showing how in Leeds popular interest was kept up and subscriptions were obtained. The two things went together; people would always find money for institutions in which they took an interest, and in the management of which they took a part. Mr. Blair seemed to set great store by a small executive committee, which was so far right; but he (Mr. Lloyd) also believed in a large board, such as they had at Birmingham, consisting nominally of 50, and seldom attended by less than 30, large enough to include all honorary officers and all members of sub-committees. The benefit was not only in keeping a large number interested, but in diminishing friction when it arose. The minutes of the medical committee, of the house committee, and of the finance committee, ought to be laid on the table at the meeting of the large board, so that any point of difficulty might be discussed with a view to finding a remedy, and obtaining an effective expression of opinion. This was all part of what he meant by a democratic basis. Every subscriber should be present to attend the annual meeting, and to take part in electing the large board, which should appoint all the other committees, and should meet, say once a month. He did not think much of what

was described as the evil of the crowding of hospitals in particular localities. There could always be more eminent medical men at a large hospital than at a smaller one or a dispensary, and patients desiring to go to the man with the best reputation for curing their complaint would travel long distances, and pass by the local hospital for the central one, where the eminent man was supposed to be seen. He was surprised to hear it said that the London hospitals illustrated the failure of local self-government; as he thought that they rather illustrated the result of the absence of it. The government of the hospitals seemed to be too autocratic and the local element was conspicuous by its absence; if they could get local government probably all would go straight, and there would be plenty of money to be obtained. But to get it there must be more of popular management, and the free movement of popular control and interest must be allowed to get into the ventilation of hospital questions. He believed that the raising of money greatly depended upon getting popular interest in, and popular control over, our institutions.

Mr. Salmond (British Home for Incurables), was surprised at the absence of suggestions from the managers of special hospitals. The system of obtaining contributions from patients was carried out more in special hospitals than in others; indeed, many special hospitals were nearly self-supporting. He was for some years secretary to a special hospital which received last year, in shilling payments, the sum of £1,204, during the period in which there were 23,000 attendances including 3,772 new cases; and the sum received for patients was within £700 of the total annual expenditure. If a working man had to give up a day's work in order to attend a hospital, he could not be expected to give much towards the cost of the relief he received. If, however, he came out of his working time there was far more ground for asking him to pay. On this account evening attendances three times a week were found satisfactory; the working man did not lose a day's pay and therefore he was more inclined to give because he had incurred no loss. The hospital he was referring to, as he was called upon to name it, was the St. Peter's Hospital for Stone, but it must be understood that he did not advocate the cause of the special hospitals, or the Hospital for Stone—a thoroughly special one. His only object was to urge that evening attendances might be made a means of reducing financial difficulties and preventing pauperisation by the granting of gratuitous relief. If men could get the relief they required in the evening they would feel far more bound to give something. All the hospital statistics that had been quoted, being returns for whole years, included, in many cases, the attendances of the

same patients at several hospitals. He had known patients go to five hospitals in a year; they were hysterical patients who went from hospital to hospital; he ascertained this from making inquiries as to whether they were proper recipients of gratuitous relief. One woman had been to nearly every institution that could be thought of; hers was a purely hysterical case. She thought she never got relief and so she went from one to another. There were perhaps hundreds of these people in every hospital book, and allowance ought to be made for them in considering the returns submitted to the Conference.

MR. BLAIR, in reply, said he quite agreed with Mr. Hordley as to the advisability of monthly returns of the cost of in-patients. At the Leeds Infirmary the accounts were made up quarterly, showing the cost of every item under the various heads. By a report book submitted to the weekly board they saw the numbers of in and out-patients which had passed through the institution, the number of eight weeks' cases resident, and the balances in the bank, with other information. These returns served as a check upon the expenditure. The plan of making a charge for the maintenance of in-patients did not seem to be much known in London. As a rule he saw the applicants himself who had been admitted as in-patients if they were well dressed, or who were supposed to be able to pay. By questioning them as to their occupation and the income of the family he was able to judge whether they were in a position to contribute anything towards their maintenance, and made the charge accordingly. The plan was a simple one and it worked very well. The same system was carried out with regard to the supply of surgical appliances. The doctors did not order them direct but sent the orders to him, when he made inquiries as to their cost and the position of the patient, and acted accordingly. A similar plan was followed with the out-patients; he went amongst them every day and by this scrutiny he was enabled to judge whether any were unsuitable to receive gratuitous medical relief. Last year about 300 people were sent away from the out-patient rooms as being in a position to obtain private medical advice. Trivial cases were also weeded out. Every year thousands of men and women presented themselves for medical relief with imaginary disorders, but who really ailed nothing at all. There was a hospital clerk who divided the applicants into medical and surgical cases. The house surgeon went through the surgical and the house physician through the medical cases, and if they deemed any too trivial for treatment they were sent away. By this means about 3,000 applicants were sent away last year. The weekly board introduced this system in the year 1879 in consequence of the out-patient department becoming so heavy that

it was impossible to cope satisfactorily with the increasing numbers. Now only forty new applicants were allowed to be seen per day, twenty by the surgeons and twenty by the physicians, unless there were others very urgent. In some hospitals the drug bill was far too high, which could easily be reduced without interferring with the supply of the best quality of drugs. It had been the rule in many hospitals for the medical staff only to look after the purchasing of the drugs and to recommend certain houses to supply them. At Leeds the doctors left it to the dispensers and himself. Once a quarter he ascertained what drugs were likely to be wanted, and had a list made out and sent round to the manufacturers and large wholesale houses requesting quotations, and in the tenders there was frequently an amazing disparity in the prices for the same quality of drugs. Acting upon this plan, and dealing with the best wholesale druggists, hospitals might save hundreds of pounds a year. Over twenty thousand patients passed through the Leeds Infirmary a year, and the drug bill was not much more than £600. Some hospitals with one half the number of patients spent almost as much. The surgical appliance question was a very important one, involving the spending of large sums of money even in comparatively small hospitals. The other day he learned that a hospital of the same size as that at Leeds had spent £600 during the year in surgical appliances, and it did not receive a single penny in return from the patients. Appliances ought not to be given away except to persons who were really unable to pay anything, and even then inquiries should first be made through the Charity Organisation Society. At Leeds there were both a house committee and a weekly board. The house committee managed everything in the house, and the ordering of all supplies. The committee met on the same day about an hour prior to the board, and their minutes were submitted to the board for confirmation. Thus everything came before the weekly board, which consisted of 22 members, 13 lay members and all the medical faculty.

XI.—*The Relation of Convalescent Institutions to Hospitals.* *By* B. J. MASSIAH, M.D., *late Resident Medical Officer, Barnes' Convalescent Hospital, Cheadle; and Physician, Sick Children's Hospital, Pendlebury, Manchester.*

This question will be better understood if prefaced by a few general remarks on the system that these institutions collectively constitute, as the literature referring to them is so scanty and scattered that comparatively little is known about the subject. No one has done for them what Mr. Burdett has accomplished for cottage hospitals, in his interesting and useful little work, classifying and describing them.

'British Convalescent Institutions' were made the subject of a Graduation Thesis for the degree of M.D., Edinburgh, in 1879, by the writer of this paper, who was then Resident Medical Officer at the Barnes' Convalescent Hospital, Cheadle, and who had visited most of the more important of these establishments, but that Thesis was not published, because in 1880 there appeared the valuable 'Report and Catalogue' of the Charity Organisation Society, giving tabulated details concerning each institution in England and Wales. Although Ireland and Scotland are not referred to in this Report, it is probably the most comprehensive authority that has hitherto been published,* and it is partly from this source, partly from previously collected data, as well as from the experience derived during a three years' residence at Cheadle, in the most highly organised of these institutions, that the materials for the present paper have been derived.

Convalescent institutions are an expansion of the system of modern hospitals that has occurred during the last half-century, and that originated as an outgrowth from these establishments, all of which but two have been built since the year 1700.† They express an attempt at the prevention of disease that is in accordance with modern tendencies, and their rapid multiplication, consequent on the success

* 'Good Words,' October, 1874, contains a brief but interesting article on Convalescent Institutions, by the Rev. F. Arnold.

† See 'Hospitals, Past and Present,' by the late Samuel Martyn, M.D., F.R.C.P., Senior Physician to the Bristol General Hospital.—B. J. M.

attending those first established, has been demanded by the urgent need for healthier conditions that is so evident to those familiar with the dwellings of sick poor, as well as by the increasing strain on the accommodation in urban hospitals.

This last cause necessitated the displacement of convalescents by others more seriously ill, and as the usual surroundings of patients' homes favoured relapse, it was obviously advisable to place those sufferers under such favourable conditions as are afforded by sea breezes, or country air, with rest, good food, and nursing.

In this way the rural character of convalescent institutions has been determined, although modifying influences, such as the necessity for frequent access, the cost of transit, &c., sometimes compelled the selection of a suburban site.

There are probably 200 convalescent institutions in Great Britain, and at least 189 are known to us. England has 169; Wales, 9; Scotland, 9; and Ireland, 2. These contain about 6,000 beds, 5,000 of which are in England.

These institutions may be classed in two divisions, according to their position, seaside and inland.

A glance at a map on which the situation of most of them is indicated shows that the former are more numerous, and are arranged in three main groups.

The first, mainly in relation to London, fringes the Southern and Eastern coasts; the second, N.W., in relation with Lancashire, Cheshire, and the Midlands, is dotted about the coast of South Lancashire and North Wales; the third, N.E., in relation to Yorkshire and Newcastle, is placed between the mouths of the Tyne and the Humber.

Scotland shows a small group around Glasgow, and two near Edinburgh. There is also one at St. Andrews, and another at Aberdeen. Belfast and Dublin each have one. The last is a small one, at Blackrock; the erection of a large one that has been planned for Dublin has been postponed to better times.

Regarding the relation of the English and Welsh convalescent institutions to hospitals, we can get only an approximate idea because few reports give separate estimates of the number of patients admitted from hospitals, and only some 24, or 14 per cent. of the institutions, are appurtenances of hospitals, or stand in direct relation to them. These 24 include many of the more important, and contain 1,236 beds that are related to 6,170 hospital beds, i.e. a ratio of 1 to 5, as the following table shows.

Convalescent Institutions.

England, 169 } 178 : 118 unrelated, 60 related { indirectly, 36
Wales, 9 } { directly, 24
24=1236 beds related to 6,170 hospital beds which is 1 to 5 nearly.

The 36 indirectly connected have only 10 to 20 per cent. of their 2,670 beds filled by hospital patients. Taking the latter estimate we get 566 more beds to add to the 1,236, making a total of 1802, but we cannot estimate the number of hospital beds that supply them except by taking the above ratio, 5—1.

Convalescent Institutions related to Hospitals directly :—

Beds.			*Beds*
7	Arrowfield Top.	Birmingham Sick Children's	72
10	Blackley, Manchester	Manchester Clinical	56
10	Bournemouth, Hip	Queen-sq., W.C., Hip. Dis.	77
63	,, National Sanatorium	London, several	500*
30	,, Herbert Memorial	Salisbury Infirmary	100
4	Brentwood Cottage	Samaritan (and London)	52*
6	Bristol, Shirehampton	Royal Infirmary, 264 / General Hospital, 150	414
4	Burstead, Essex, Children	London	20*
100	Buxton, The Devonshire	18 Infirmaries in Lancashire and Cheshire on the Cotton District Fund	1052
150	Southport, Conval. Home		
30	,, Children's Sanatorium		
134	Cheadle, Barnes Conval. Hosp.	Manchester Royal Infirmary	315
20	Finchley	Queen-sq., W.C., Nat. Epileptic	120
40	Hemel Hempstead	King's and University College	200
52	Highgate, Cromwell House	Great Ormond-st., Children	120
34	,, Lauderdale ,,	St. Bartholomew's	676
10	Isle of Wight, Bonchurch	Royal Hants, Winchester	110
30	Leeds, York Road	Leeds Fever Hospital	80
14	Margate, Churchfield	Chelsea, Victoria, Children's	65
66	Meltham Mills	Huddersfield Infirmary	100
23	Paddington, Mary Magdalene	Queen Charlotte's	50
300	Walton-on-Thames	University College, &c.	1500*
90	Wimbledon, Atkinson & Morley	St. George's	353
9	Wingfield	Oxford, The Radcliffe	138
1236			6170

The percentage of beds for convalescents, supplied with patients from individual hospitals, varies from 1·5 per cent. at Bristol to 42 per cent. at Cheadle, and nearly 44 per cent. at Cromwell House. The pressure on hospital beds seems greatest in the case of children, 7 of the 24 institutions directly

* Approximation.

related are for children, and they are constantly full. If this maximum of 44 per cent. were allotted to all the London hospitals, nearly 2,000 beds would be required for them alone, and remembering that this accommodation would be exclusively for in-patients, and would, probably, be inadequate, what would suffice to receive the out-patients that should be sent? Surely double the number, or 4,000, would prove a modest computation; *i.e.*, two-thirds the convalescent beds in Great Britain are, probably, too few for the needs of London by itself. Yet we find that only six London hospitals have convalescent institutions belonging to them, whereas every hospital with more than 50 beds should most undoubtedly have its own convalescent institution, and pass on to it not merely those patients recovering from acute disease, or injury, but all such invalids as are drifting downwards; all the chronic cases; all those requiring preparation for operation, as well as such incurable cases as phthisis, cancer, &c., that require careful attention to the last. The need of convalescent institutions in connection with children's hospitals in towns has been truly and forcibly put forward by Mr. George Arthur Wright, surgeon to the Pendlebury Hospital for Sick Children, Manchester, who writes:—

"The two great classes of patients applying for relief, excluding epidemic diseases and diarrhœa, are,

1. Those suffering from disordered nutrition, so called, including in these the vast numbers of ricketty children.

2. Those with chronic diseases of bones and joints, the scrofulous series.

In series 1, the majority require not active treatment but proper food and good air for long periods of time; such cases clog the wards for indefinite periods and do so the more because the second requisite, good air, is not forthcoming in the central institutions that are necessarily in, or close to, large towns so that they may be easily accessible from the centres of disease, and that acute cases may reach them immediately; but none the less the majority of patients suffer from chronic disease.

In the second, or scrofulous series, including the chronic diseases of bones and joints, are two classes.

(*a*) Those in which disease has so far progressed that operation, or active treatment of some sort, is necessary at once.

(*b*) Those in which the need for such treatment will be averted by good food and fresh air, especially sea breezes,

for a sufficient length of time. Both these classes urgently need removal to convalescent institutions, the first to recruit after operations, the second, that they may avoid the necessity of entering class (*a*).

By far the larger proportion of surgical out-patients would get well with the simplest treatment if they could be sent to seaside institutions where good food and nursing are available *for a sufficient time.*

Town hospitals must exist for the receipt of acute cases and those requiring active treatment, but they may be diminished in size and number with the greatest advantage, if sufficient accommodation at the seaside for convalescent and chronic disease was substituted, and it would, no doubt, be more advantageous to the children of towns than the present system. The convalescent institutions must be of much greater capacity and number than the town hospitals, probably two or three to one; and preferably a few very large seaside institutions, accessible to different sections of the country, than many small ones, *e.g.* one, or at most two, for Lancashire and Cheshire, on the coast of North Wales, so as to accommodate a greater number for a longer time than can be allowed at present; so many cases require to remain for 6 or 12 months, or even longer."

A strong argument in support of these suggestive remarks is derived from economical considerations. Convalescent beds are cheaper to maintain, as well as more salubrious, than those in town hospitals can be, ranging from £20 to £46 per bed, the increased cost attending those, as at Cheadle, where the cases and arrangements approach more nearly to those in a general hospital. It seems, then, as if humanity and economy will combine to cause a great extension of convalescent institutions partly at the expense of town hospitals; some of the latter must always remain as receiving houses and as educational centres, of smaller dimensions, whilst others will migrate to the country or seaside, following the example of the union infirmaries and large asylums; in which case it will be as well for those who plan extensions of existing town hospitals, especially for children, to consider whether it would not be better to start an offshoot outside the town, or expand any convalescent institution existing there.

The anomaly of one-third to one-half of the present convalescent beds remaining usually empty, although the total number is far short of what is needed, is due partly to want

of organisation, and will pass away when the benefits of a residence in a convalescent institution are more appreciated, and more present to the mind of those managing town hospitals; it is also due to want of funds, and may be partially remedied by exacting payment from those able to afford it.

The existing supply of beds should be utilized before additions are made, and a right step in this direction has been taken by the Charity Organization Society, in renting beds at convalescent institutions, and placing them at the disposal of certain hospitals, thus on a small scale following the example of the Cotton District Fund. The governors of this fund have spent an average sum of £900 per annum in this manner, since 1876, and will probably expend £2,500 in 1883. The rate of payment has been 16s. per week per bed occupied at Buxton and Cheadle, and 12s. per week per bed unoccupied at the latter, for any of the 16 beds rented there that might remain empty. Next year when the new home at Southport is opened, a charge may be made to the patients, if the ordinary income of the fund, £4,000 per annum, is insufficient to support all the 330 beds that will be at the governors' disposal, so as to keep intact the capital of £100,000.

The fund originally amounted to £157,000, and was a surplus of the cotton famine fund; £57,000 of it, and accumulated interest amounting in all to £74,000, have been expended in extending the accommodation at Buxton and Southport.

At the former place the governors have paid £24,000 for the first claim on 150 beds at the Devonshire Hospital, *i.e.*, at the rate of £160 per bed.

At the latter, Southport, they have paid £2,500 for the preemptive right to 30 beds at the children's sanatorium, *i.e.*, £83 6s. 8d. per bed; and they have spent about £46,000 in building a new convalescent home to contain 150 beds in connection with the Southport Sea-bathing Infirmary, *i.e.*, £307, nearly, per bed. Thus, for £72,000 they obtain 330 beds at an average cost of £218 per bed. Of these 280 will be allotted to 18 hospitals in Lancashire and Cheshire having more than 40 beds each, which will afford about 26 per cent. of convalescent beds to hospital beds, and the remaining 50 will be retained by the governors for allotment to other hospitals in the same counties having less than 40

beds each.* If these convalescent beds are to be maintained by the fund, the present income will have to be doubled or trebled.

Before concluding this paper we may briefly notice the progress of convalescent institutions in Scotland.

Dunoon and Lenzie on the west, and Corstorphine on the east are the most important. The two former are in relation with Glasgow and provincial infirmaries. Dunoon, one of the largest in the kingdom, received last year from them 1873 out of 2,600 patients, although not directly related to any. Lenzie has a direct connection with Glasgow, 30 out of its 67 beds being allotted to the Royal Infirmary and 10 to the Western Infirmary. Corstorphine with its 60 beds belongs to the Royal Infirmary, Edinburgh, and a house fitted for convalescents after fever has just been presented to the same infirmary.

Ireland has at present too few convalescent beds to deserve more than a passing notice.

The question of accommodation for fever convalescents is pressing for consideration, and especially for those recovering from scarlet fever both to promote recovery and to check the spread of the disease. We are glad to see that a convalescent home is being prepared for this class at Stanmore, near London, by the efforts of Miss Mary Wardell, and we trust it is but the first of a series.

In conclusion we may obtain a further idea of the whole subject of accommodation for convalescents by roughly estimating the sum annually expended in maintaining them and the capital it represents, viz.: about £170,000 for maintenance, and £4,250,000 capital.

* The above particulars are taken from information kindly supplied by the Secretary of the Cotton District Fund, John Watts, Esq., Ph. D.

I wish to take this opportunity of thanking those ladies and gentlemen who have kindly forwarded to me information relating to the institutions with which they are respectively connected as managers or secretaries, and whilst gratefully acknowledging their aid I should like to ask them for further help in the way of annual reports, &c., whenever a new one is issued. B. J. Massiah, M.D., Didsbury, Manchester.

XII.—*On the same. By* LEVESON E. SCARTH, *Hon. Secretary of the Convalescent Committee of the Charity Organisation Society.*

In preparing these few remarks for your consideration to-day I have confined myself to the general question how can the relations of convalescent institutions to hospitals be so improved as to bring them into close and intimate connection.

Taking first a survey of the state of affairs as at present existing, there is found to be but a small amount of direct connection between the many convalescent homes that are scattered about the country, and the hospitals, as regards their in-patients, whilst as regards out-patients there may be said to be almost none at all. Putting aside those hospitals which are fortunate, or enterprising, or far-seeing enough, to have private convalescent homes of their own attached to the establishment and forming an integral part of the whole machine, the relations of most hospitals to homes are not the conscious result of definite efforts at organization, but the growth of a custom of sending their patients more to this home than to that, owing to the friendly aid of particular subscribers who are in the habit of forwarding their "letters" to the hospital. Now this arrangement, good so far as it goes, certainly lacks purpose and definition. It is not altogether reliable, and so far indicates a "living below privileges," in that it takes very little into account the large number of small homes which are established in so many country villages and which are often sadly in want of patients because they are so little known. These smaller homes, and I say it without disrespect to the magnificent and well-known institutions which we are accustomed to associate with the words "convalescent homes," represent to my mind all that is best in convalescent work. They represent in a way which the large institutions cannot quite do, the latter half of the expression. They are in a special sense "homes" provided, furnished, and regulated by ladies who, for the most part, give their whole time, and often all their available money, to increase the happiness and comfort of the convalescents whom they receive. I know of nothing more pleasant than to make (as I am now engaged in doing),

visits to these smaller homes, hidden away, some of them, in country villages; but furnished and made ready with abundant care for the convalescents, who at first are so slow in coming, because the home is as yet unknown.

Many of these small homes, moreover, have one room set apart for a class of persons who are supposed to be able to tend for themselves, but who often would be glad to be laid up in lavender for a week or two, and have everything done for them by way of a change and rest from their continual routine of serving others. These rooms are often empty because sisters and nurses have no means of knowing how welcome they would be as their fittest occupants.

While it may be conceded that a private home attached to each hospital is in a measure the ideal, there is I think little doubt that the number of hospitals attaining this ideal is never likely to be large; although the possession of a home to which patients can be sent at once when they are ready, without any prolonged waiting for admission, is in the long run probably an economy both of time to the patients and of money to the hospital; in that it allows the benefits of the institution and staff to be extended all the sooner to fresh patients. Still the large expenditure which such a private home necessarily entails is a most serious matter for a hospital to meet, and it is plain that the struggle for bare existence and the anxieties of self support are too severe to allow many hospitals to add to their burdens another heavy weight. It is not therefore generally possible for hospitals to add to their responsibilities the care and maintenance of a convalescent home. But fortunately there are plenty of people ready and willing to establish and maintain convalescent homes of their own, either with the aid of subscriptions or out of their own funds.

The usual way in which a home is managed financially is simply this:—

Establishment expenses such as rent, rates, taxes, and wages, are paid either by the foundress, aided sometimes by her friends, if it is a private home; or by the public, if it is a home managed by a committee.

The portion of the subscriptions which go to the establishment expenses is, in a majority of cases, the money of those subscribers who are not careful to use their letters, or, better still, who are careful not to use them.

Every letter used means a convalescent patient boarded for say three weeks *but not lodged* the lodging, or, in

other words, the establishment expenses, have to be provided by the money of those who do not use their letters. Hence it follows that the collection of letters and their more extensive use by hospitals and others, is a method of meeting a part of the difficulty which is simple and fairly effective at first sight, but in the long run most injurious to the homes; for the balance of used and unused letters is so narrowly calculated that the collection of letters and their extensive use on a large scale would involve many convalescent homes in serious difficulties. This then is hardly to be thought of; some other plan must be found if hospitals are to find accommodation for their patients.

Although the hospitals are full all the year round, it is especially during the summer that the world is taken with this convalescent idea, and the best known homes are then beseiged with applicants, until even the possession of a "letter" hardly brings the patient within a measurable distance of admission,—so long is hope deferred at these modern Pools of Bethesda. This rush for convalescent beds during the summer months, and the consequent delay, might in a measure be avoided by the plan I would here propose, and which is based upon an extension of a system adopted in a few cases already by hospitals, and being developed at the present time by the Charity Organization Society for the cases sent by their district committees. It is that of having permanent beds reserved by pre-payment, either for the whole year, or only for the summer, and kept exclusively for the use of cases sent by the hospital. This plan is in working order to a limited extent already, and where it has been adopted it has, I believe, given satisfaction on all sides—to the home because it assures them, by so much, a fixed income and less trouble in letter writing, and some guarantee for the case; to the hospitals, because the amount of accommodation is, so far as it goes, available with certainty; and to the patients, because they either have not to wait, or the length of their waiting is accurately known.

It may be urged that this plan of permanent or summer beds does not commend itself to some homes; and this is true. It must be left to the managers of the homes to say whether they think it advisable to fall in with such a scheme; but speaking from experience, and alluding more particularly to smaller and less well known homes, I have little hesitation in saying that there is no lack of accommodation to be obtained on terms of pre-payment and reservation.

Reservation of certain beds is no hardship to the general public and to others out of hospitals who compete for general vacancies, because firstly, there are some homes which will always keep their beds for general applicants; secondly, not all the beds even in one home need be reserved; and thirdly, the supply of homes will increase if there is a demand,. They are even now increasing in number every year.

As to the manner in which the arrangement could be made: either it could be left to the hospitals to make their own terms and agreements with the homes, in which case the hospitals would find the money themselves; or the arrangements could be made by a central committee, upon which every hospital might have an in-patient representative, and which, in order to relieve the hospitals of any additional burden, might collect a convalescent fund; and in conjunction with, or after the manner of, the committee of the Hospital Sunday Fund, allot the accommodation obtained by the convalescent money to the various hospitals according to their needs.

This convalescent central committee would be a standing committee working all the year through, but especially active during the summer months.

It would act as a rallying point for the homes on the one hand, and for the hospitals as representing the sick poor on the other.

It would be a telephonic central exchange office, both metaphorically and, in time, actually; for such a work as this may eventually be carried on most smoothly by the telephone.

It would substitute by degrees order for disorder, and saving of time for waste.

It would encourage small homes by providing suitable patients, and utilize large homes without interfering with their present methods and constitutions.

It would lastly act as a useful centre of information for the general public; and as trustworthy recipients of the fund which it would obtain and use for the benefit of the hospitals and the homes, not by diverting into another channel the contributions of present subscribers, but by creating a large class of subscribers at present non-existent, but willing to appear if they only knew the need.

It may be said that this a tolerably wide scheme, and what prospect is there firstly that the workers would be forthcoming and secondly that the money could be obtained?

As for the workers there would, I venture to think, be small difficulty.

Convalescent work is emphatically women's work, and who will say that there is any lack of capable and energetic women not merely willing but eager to spend themselves and their time in work such as this.

The sisters in charge of the wards of any hospital could amongst them, I doubt not, name some lady as earnest as themselves who would take especial charge of the convalescent affairs of their hospital and serve as a representative on such a central committee. As for the money, it is hard to get.

It is difficult indeed to know how to get the ear of the public for charitable work. Some weeks ago a letter, containing an appeal for just this work which I am now advocating, was put into the daily papers by the Charity Organisation Society, and the money it has brought in amounts to about £150, although there is scope for the expenditure of a thousand pounds at the very least.

Every one engaged in charitable work tells the same tale; but yet I, personally, hold a firm conviction that the fault lies not so much with the tied-up purses of the public as with the manner in which the public is approached.

I believe that the very name of convalescent work, and the certainty that their money would be applied with judgment and care, would cause people to follow their instincts, and give freely, and even lavishly, when the approach of summer brought to their minds their own customary and much needed holiday.

By degrees a class of subscribers would be created who would feel that they could not thoroughly enjoy their own share in the general August outing if they had not, before they left their houses, ensured a like refreshment to one at least of the sick and weary poor.

Turning now to the out-patients, an enormously more numerous though not more necessitous class from a convalescent point of view, I am warranted in saying that the Charity Organisation Society aims at so developing its convalescent work that it will in future, by degrees, be enabled to take entire charge of the convalescent needs of all the out-patients from the London hospitals. The plan upon which they propose to deal with the cases sent from the out-patient departments is as follows:—

They propose to furnish the out-patient physicians or surgeons with books of medical certificates, drawn up in a simple and approved form, and bound like cheque books with counterfoils.

The doctor would be informed on the inside of the cover of the class of patients who were eligible, and the class who were ineligible, and whenever he found an eligible case the student who was "clerking" at the time would fill in the details required, and the doctor would sign his name.

After that the Charity Organisation Society would take entire charge of the case, for on the back of the certificate would be printed a list of the thirty-nine district committees of the Society with instructions to the patients to go to the one nearest to their own place of abode.

The Society would then make necessary inquiries and arrangements for dealing with the patient, and if the case were found "ineligible" from causes other than medical, would write to the doctor whose signature was on the paper, and inform him of the reasons for declining to assist. If the patient was found in all ways eligible the doctor would hear no more about it.

If any plan more simple than this, and giving less trouble to the hard-worked doctor can be designed, the Society will be heartily glad to receive the suggestion.

The plan is, however, liable to two dangers, and I have sufficient confidence in the large-mindedness of the medical profession to state them here with some boldness.

One is that the certifying physician or surgeon will not be sufficiently discriminating in the cases he selects for convalescent assistance; and the other is, that both he and the patient will look upon the certificate as an "order" for admission.

With regard to the first danger, I sometimes think that doctors would be surprised to hear how carefully the homes have need to guard themselves against the assaults of the doctors. Convalescent homes seem with some to be looked upon as places for the residuum; for those cases for which little more medically can be done; or as convenient receptacles for inconvenient fits and other like infirmities, or even as affording the best lawful chance of "euthanasia."

But the cases the homes desire to receive are those that will be more or less substantially or permanently benefited by their stay in the country or the seaside.

And here let me impress upon the signers of certificates that it is always a great advantage if the question seaside versus country is left an open one. Of course in a large number of cases seaside change is imperative, but in many others the country would do as well, and seaside accommo-

dation is very limited and consequently expensive compared with the country.

Quite apart from homes, accommodation in the country can be obtained to almost any extent by developing the admirable plan of boarding-out in village cottages; whilst this is not only inadvisable but impossible in seaside towns.

With regard to the other danger, that the certificate will be looked upon by the doctor and patient as an "order," I will only note that the circumstances and home surroundings of the out-patients are of course quite unknown to the physician, and when the C.O.S. find that the person presenting the 'order' has, as in one instance, a near relative with an income of £4,000 a-year, or as in other instances too frequently, is unsuited for close association with his more respectable fellow-creatures, the Society must refrain from helping what was in a medical point of view a good convalescent case.

And not only is the aim of the Charity Organization Society the convalescent relief of out-patients, but the Society feels most strongly that a hospital is a place where are brought together the very fittest objects for charitable aid that can be imagined.

At a hospital they have not to be sought out; they come driven by stern necessity to seek relief.

That relief the patients receive abundantly, and to the utmost power of those noble institutions, but behind the visible distress of these evident sufferers is a large amount of hidden misery which is as much a part of the 'case' as the affected chest or the paralysed arm. The family at home—what of them? The patient recovered after a month in a hospital and three weeks at a convalescent home—what of his or her prospects of a livelihood in the future?

Even when supplemented by a Samaritan fund, medicine, and surgery do not really comprehend the whole malady and take possession of the whole case, including in their action every member of the family affected.

And yet this would represent a cure in its perfection, from an all-round point of view.

Hospitals, then, bring to a focus misery and are so many centres round which should cluster a congregation of accessory aids; of those the most obvious are convalescent homes; let us begin therefore with 'organizing convalescent aid.'

XIII.—*On the Necessity for a Royal Commission of Inquiry.* *By* Sir Rutherford Alcock, K.C.B., D.C.L.

Local self-government has many advocates, and there is a great disposition to consider it not only a good thing in the abstract, but equally applicable and good for all administrative work and conditions. The very object of the present Conference, and of this paper more especially, offers a triking contradiction to any such unqualified assumption. For as regards hospitals and their administration throughout the country, local self-government reigns supreme, and whatever advantages may attach to it as a principle, the outcome in respect to the hospitals of the metropolis especially, and their administration, is by almost common consent considered eminently unsatisfactory. It is this consensus of opinion which has originated a movement for authoritative inquiry by means of a Royal Commission, as a matter of primary importance and urgency. Nor is this an opinion of sudden growth or of very recent origin. During the last five or six years, at least four deputations have sought interviews with the Home Secretary. On one of these occasions I attended with others interested in the administration of metropolitan hospitals, the object of which was to urge upon the then Home Secretary (Sir Richard Cross) the desirability of such an inquiry as only a Royal Commission could satisfactorily carry through to a practical end.

The reception given by the Secretary of State to the arguments employed in support of the proposition, was not of a nature to give much hope of government action or assistance. He seemed to think that if anything were wrong in the administration of the London hospitals, the various independent governing bodies had the remedy in their own hands, and might introduce such changes and reforms as were needed to effect the desired improvement. But it was obvious that in this view, the Secretary of State entirely overlooked the main fact which dominated the whole question, namely that being isolated and independent, there was no spirit of combination and co-operation among the units to work to any common end. And without this, many of the graver abuses and defects from which the sick and poor

of the metropolis, the medical staff, and the public at large all suffered grievously, could not be reached, or any effective remedy applied. All experience might have suggested another conclusion, not less adverse to any hope of material improvement—without the exercise of some controlling power to enforce changes which the circumstances rendered necessary. Municipal bodies and institutions under local self-government have never shown any great aptitude for originating reforms, though prolific in expedients for perpetuating existing abuses or defects. And the dislike to be improved, or interfered with from without on any plea of improvement, is inherent in all self-governing bodies, moved by a doubt as to the results, and a natural instinct of self-preservation. All external authority acting as a centre of control must of necessity encroach upon the principle of self-government and local administration. It cannot well be otherwise. Nevertheless it is no less certain that if the large endowments and the annual income contributed to the maintenance of public hospitals in the metropolis are to be so managed and distributed as to form any adequate provision for the sick, who now seek assistance from medical charities, there must be great changes and reforms, not only in administration but in the location and management of the hospitals. Their present distribution in the area of one hundred and twenty-two square miles which greater London covers under the poor-law and for registration purposes, is so faulty that nothing worse can be conceived. A better division of the funds, and some better security for the sums actually required being forthcoming to meet the legitimate demands upon them, are imperatively needed. The insolvent and bankrupt state of nearly all the London hospitals dependent on voluntary contributions is an increasing evil. The multitude of smaller special hospitals and dispensaries each year also increasing in number, and located at random, or, as may best suit the convenience or interests of a few individual promoters, all contribute their quota of increased demands on the general fund available for charities. The majority of these are maintained with difficulty, if we except the three great endowed Hospitals of St. Bartholomew's, Guy's, and St. Thomas's. These three, with a capital estimated at millions, but available for no others, are so many evidences of a want of method or intelligent adaptation of means to an end, and a proof of the necessity for a Royal Commission of inquiry, to reduce a chaotic state of disorder and waste to some

systematic provision, for the sick poor, who require public aid. For the preservation of the public health during epidemics, when not the poor only but large numbers of the working and middle classes require accommodation in the wards of a hospital, some special provision has been made, as the only means of securing the necessary isolation and averting a great danger to the whole community, by the spread of infectious diseases in their midst. The Local Government Board, by the Asylums Board, has provided hospitals for such cases maintained at the public expense.

So much, however, has been written on this subject that it is very difficult to suggest anything new for consideration. Dr. Gilbart-Smith in his paper on "What Reforms are desirable in the Administration of Hospitals," read at the Social Science Congress in Nottingham last autumn, with the accompanying carefully compiled tables of Dr. Mouat, goes over the whole ground in a very complete and exhaustive way. An interesting discussion followed which still further elucidated both the defects of the existing order of things and their remedies. Taking this in connection with the memorial of the Council of this Association forwarded in May of last year to the Home Secretary, and its accompanying 'explanatory memorandum,' setting forth some of the more cogent reasons on which the eight resolutions contained in the memorial were based,—there would really seem little more to be said, and in addition we have now the able and exhaustive paper of Mr. Burdett read at this Conference. Nevertheless, since a deaf ear was turned to the memorial and its prayer, and it was thrown aside for want of time, or until a more convenient season, the necessity still exists for reiterated appeals and further effort to obtain the authoritative inquiry so urgently required. To avoid, however, the wearisomeness of a twice-told tale as far as possible, I will only glance in a very cursory way at a few of the more salient arguments and facts which justify the continuous efforts not only of this Council but of a very large following of the medical profession, and of those who are actively engaged in hospital administration in London and elsewhere.

And first as to the facts upon which these general considerations are founded. They may be stated very briefly:—

The population of London by the last census, in the 38

Union districts of the Poor Law Board, amounted to 3,831,719, spread over an area of 122 square miles, equal to a square of about eleven miles to the side, while the length of the streets and roads is about 1,500 miles. Amidst this teeming population of nearly four millions with a total mortality in the year of some 80,000, (in 1881 it was returned by the Registrar General at 81,071), and the annual rate of deaths per 1,000 of 21.2, there are scattered very much at random some 200 institutions for the purpose of supplying gratuitous medical relief. The proportion of sick to mortality is difficult to estimate, as is also the proportion of the poor and working classes requiring hospital treatment, to those that can be provided for at their own homes. But the approximate number of those who seek medical treatment at the several hospitals and dispensaries, either as out or in-patients, is not so difficult to ascertain. They have been roughly stated at a million. But we know with great certainty that at the 93 general and special hospitals and convalescent homes which are participants in the Hospital Sunday Fund, the total number of patients admitted into the wards in 1882, or treated as out-patients was as follows :—

Number of in-patients 64,080 ; number of out-patients, 550,218 ; and in 52 dispensaries the number of new cases were 233,582 ; and of midwifery, 7,039. That would give a total of 847,880, exclusive of the 7,039 midwifery not received into hospital but patients requiring attendance at their homes if not in the wards of a hospital. Of course this enumeration does not include all the medical relief afforded gratuitously in the area of the metropolis. There are many dispensaries, provident and free, and some special hospitals not included in the Hospital Sunday list. And in addition all the Asylums Board Hospitals which are excluded, as well as the provision made by the poor-law guardians for the pauper poor in the various parish and Union infirmaries. Apart from these last, therefore, it may confidently be assumed that the number of the population in the metropolitan area habitually seeking and obtaining gratuitous medical relief does not fall short of a million, or one-fourth of the whole population. This for a long time was stoutly denied as an exaggeration, but I think with these returns of the Hospital Sunday Fund to guide us, there can no longer be any question about it.

The chief evil of this state of things perhaps consists in the alarming fact that one-fourth of the lower, middle, and

the working classes, are not above seeking charity when in sickness, and contribute nothing towards the expenses of their maintenance. There must be many of these recipients who could afford to pay the whole, and still more in number who could contribute a part, if the opportunity were afforded in our public hospitals, and fewer facilities given for obtaining it gratuitously. As it is, with such facilities temptations to pauperize themselves by becoming mendicants for medical relief are thrown in their way.

Of the many evils, abuses, and defects attending the administration of medical relief in the metropolis, I doubt if there be any one more injurious in its effects than this. The whole system is converted into a means of pauperizing the working classes, and a large number of those immediately above them—little shopkeepers and tradesmen and others in receipt of small incomes. And the first step towards the removal of this abuse would be to have paying wards or accommodation in all our hospitals, by which those who were able to contribute either the whole or a part of the cost of their treatment and maintenance in sickness could have the opportunity of doing so and preserve their self respect instead of accepting charity under false pretences of destitution.

The same principle should be applied to the admission of out-patients, and the opportunity at least afforded to the poorest applicants, of paying according to their means some quota towards the cost of their treatment. This would be a great and undoubted benefit to those who apply for medical aid—quite as valuable as any derived from medicines, and by diminishing the numbers now over-crowding the waiting rooms of hospitals and dispensaries (many with trifling ailments) would diminish the distress and loss of time in long waiting for the remainder. It would further have the enormous advantage of relieving the medical staff from demands beyond their strength, tending to a hurried and perfunctory practice from sheer want of time to do better, and of giving the necessary consideration to each case. Patient and medical man would both profit greatly by such a change from the existing state of things.

We have been dealing with the moral and physical effects of overcrowding and other deteriorating influences on patient and physician. But there is another aspect of a very serious character which presents itself as proceeding in part from the same causes under the head of *Finance*. It is no exaggeration

to say that the great majority of the medical charities, hospitals, dispensaries, and convalescent homes, in and about the metropolis, dependent on voluntary contributions, are in a quasi-insolvent state. Dr. Gilbart-Smith, in the paper above quoted, enters in great detail into this question, and more recently Mr. Burdett. Not only are the incomes of these institutions insufficient to meet the annual expenditure, and precarious to the last degree, with a marked tendency to decrease—but there is a total want of funds to meet the urgent need of further accommodation in large and populous districts where no hospitals of any kind exist. Owing to the diversity of systems in keeping the books and accounts of the different hospitals and charitable institutions, it is not only impossible to institute any comparison between the relative incomes and expenditure of each (in itself a great and prolific source of abuses), but it is impossible to arrive at any close estimate of the annual amounts contributed by the public to their maintenance. Of the three great endowed hospitals St. Bartholomew's, Guy's, and St. Thomas's, we do learn approximately at least the amount of their capital, and average income and expenditure. But of all the rest, with or without some partial endowment, it is difficult to arrive at any reliable data. Even the returns made to the Hospital Sunday Fund, by the participants, and the mode in which they are tabulated for the guidance of the council and committee of distribution fail to supply all the necessary information. Thus, when according to these returns the average amount of the expenditure in the last three years for 93 hospitals and convalescent homes is given at £516,724, it is necessary to deduct therefrom the aggregate amounts of legacies *invested* and not *expended*, though appearing as expenditure. And the same remark applies to dispensaries where the average expenditure is returned as £36,537, though in these institutions the amount of legacies which may be invested as surplus income in any three years is in all probability very small. In Howe's "Directory to the Metropolitan Charities" for 1882, the amount of income given there for 83 general and special hospitals for 1880-1 is £505,365, and for 104 dispensaries and convalescent institutions £102,674, or a total of £608,039. But if we add the estimated income of the three large endowed hospitals, and many others not included, the annual income of all the medical relief charities cannot be taken to be much under

three quarters of a million sterling—divided very unequally among some 200 of such institutions.

What strikes the inquirer into these financial statistics the most forcibly is the amazing waste there must be for so many separate administrations, in cost of management, apart from increased cost of maintenance. And when we pass on to consider the distribution of these numerous institutions for the sick of the metropolis, a stranger would be still more struck by the obvious fact that while 10 of the principal and largest general hospitals are all grouped within a radius of one and a-half miles from Charing Cross, giving 3439 beds for that region, the whole of the north-east and west of the wide area of 122 square miles, with a population of millions, has only 5 hospitals affording respectively 33 beds in the north, 810 in the east, and 232 in the west; 1,075 in the whole out of a total of 4,514 in the metropolitan area, and its four millions of inhabitants. Nothing could be conceived more injurious, inadequate or unfortunate, than such a distribution for the sick poor.

Under the three heads therefore of over-crowding in some districts, and inadequate provision in others, pauperization of the applicants for medical relief, and waste of money and strength, we have summarized so many arguments of the strongest kind for inquiry and amendment.

There are indeed many other subsidiary grounds for strenuous effort to obtain both these objects, but I really hardly think more will be needed. While there is a great waste of funds, medical skill and administrative power, there is on the other side an increasing deficiency of means to meet under these disadvantages, the most necessary wants of the sick poor of the metropolis generally, where there are many who cannot be classed as poor and yet seek relief at hospitals in sickness. While three of the endowed hospitals retain the corporate monopoly and exclusive use of a capital of several millions, and an income far exceeding the wants of the sick who find relief within their walls, many other equally useful hospitals are in danger of having to close up their wards for want of necessaries, and are in a state of insolvency. The inhabitants of whole districts of vast area are totally without any hospital within miles of their homes. Whether any more equal distribution of hospitals over the whole area and a more beneficial application of the accumulated capital directed now to three only, or locked up in obsolete charities, if not lavishly spent in other ways can be effected, is

matter for inquiry. Originally destined for the "poor sick and impotent"—who have long been driven into other districts and ceased to supply parochial applicants within the narrower area—the destination of these funds is a question that may fairly be asked, but can only receive a satisfactory answer through a Royal Commission.

When the five Royal City Hospitals were granted for the benefit of the poor and the sick in the reigns of Henry VIII, Edward the VI, and of Elizabeth, the population of the City numbered perhaps 100,000, and we learn from a note in *Manninghám's Diary* that there were of these no fewer than 30,000 dependent more or less upon charitable relief. When St. Bartholomew's received the charter from Henry VIII, the endowment amounted only to £666 per annum, half from confiscated ecclesiastical property and half from voluntary contributions from the citizens. At the latter end of Edward VI's. reign, the revenue of St. Thomas's Hospital does not seem to have exceeded £3,291 and of this sum £2,914 was from the private purses of the citizens. The endowments of the five Royal Hospitals in Edward VI's. time may be set down as almost worth £50,000, but now if we take into reckoning the actual means and the value of the hospitals and ground together, with reversionary value of leases, they represent a total value it has been credibly estimated of from 10 to 11 millions sterling.

It may of course be observed in reply that we, the outside public, had no concern with the amount of capital locked up or expended by the trustees of these or other charitable endowments, and that any compulsory application of their funds to other hospitals to be erected where most needed, would be robbery and spoliation. But in an article in the *Contemporary* for March, 1878, by Mr. W. Gilbert, "On the abuse of Charity in London," as illustrated by the history of the five Royal Hospitals, the origin of these endowments is traced to the confiscation by royal authority of the religious houses at the time of the Reformation, when the poor were deprived of the charitable relief which had been bequeathed to them by the piety of former ages. So that the history of the five Royal Hospitals, including St. Bartholomew's and St. Thomas's as two of them, began by an act of confiscation diverting the gifts of former benefactors from the specific purposes willed.

If there were any force in the argument, therefore, that it would be an act of spoliation to interfere with the present dis-

posal of such endowments, so enormously increased in value by the unearned increment of centuries, it might be reasonably answered that a similar act created them, and the sources of wealth they now dispose of are not, or should not be, at the uncontrolled disposal of any trustees or governors, beyond the reach of inquiry as to their proper and beneficial use.

It has been publicly stated, for instance, that the governors of St. Bartholomew have recently occupied land worth, it is estimated, £40,000, and, with the consent of the Charity Commissioners, applied £50,000 of the funds for charitable relief, to buildings for a new school. Guy's Hospital similarly applied £40,000 for the improvement of the Medical School, and St. Thomas's on its removal from the borough of Southwark was also allowed by the Court of Chancery to use the sum of £30,000 in the erection of their school buildings. How many hospitals would these amounts have built in Southwark, and the north and east of the City of London where now there are none? The pupils of these schools supply a large income from which school expenses might very well and properly be supplied, in the larger hospitals certainly, where the number of students range from 300 to 500 or 600. At the rate of £30 per annum, taking St. Bartholomew's at 550, the income would be equal to £16,500 per annum, a portion of which, after remuneration to the professors, might, one would suppose, accumulate to meet all charges for school buildings. I don't attach great importance to the strict accuracy of these figures, which I have not verified. It is sufficient that they fairly and approximately represent a vast accumulation of capital and lavish expenditure of income destined in their origin for the sick poor of London and not of one district alone, as a reference to their Charters show indisputably. And as this metropolis and its population have taken wider dimensions, so have the capital and income of the charitable endowments, and they should in common justice and humanity be applied over the whole area and in the best and most economical manner for the public benefit, and not according to the whims, caprices, or interests of self-elected representatives of the original donors in the tenth generation. It has often been observed that the palatial blocks of St. Thomas's were placed where they were not required by the sick poor—within a stone's throw, almost, of two or three old-established hospitals—and all the south and east and west of the wide district of Southwark were left without provision, and miles away. The

expensive character of the site and buildings I believe absorbed something over half a million sterling—or some £800 per bed. But the hospitals built of late years, under the Local Asylums Board, with every sanitary appliance and constructive excellence, have not cost, I believe, £100 per bed. The Poplar and Stepney Sick Asylum, erected under the Local Government Board's direction, where no cost has been spared in thoroughly adapting it for hospital purposes, and which is described as being inferior to no hospital in Europe in excellency of construction and sanitary appliances, it is stated cost for 600 beds a sum not exceeding £100 per bed. Compare this with something like £600,000 for the same number in St. Thomas's instead of £60,000. The capital unwisely absorbed in St. Thomas's would, on this calculation, if built where they were most wanted, have provided eight or ten hospitals of 200 beds each and income to maintain them, in part if not entirely. It is such abuses of charitable funds as are here indicated, and there are many others still less defensible, which might most advantageously be inquired into and remedied, to the great benefit of the sick poor in the metropolis. The grip of the "dead hand," is no doubt hard to relax. But there has been more than one Act of Parliament dealing effectively with bequests in mortmain—and it is no longer possible to contend that there is something too sacred in charitable endowments to permit of interference or inquiry even to avert waste or misapplication.

I would only add a very few words more in reference to the means which might be taken to supply the manifest deficiencies of hospital accommodation in the large districts now left wholly unprovided, and also for supplementing the funds of hospitals now in great measure, though very inadequately, supplied by voluntary contributions. Once the necessity of some kind of State control or intervention is demonstrated, if such deficiencies are to be supplied, and existing abuses removed, we may take suggestions from what has been done in other countries. In Paris, when, in the Revolution of 1879, the charitable and other endowments shared the same fate as our monasteries under Henry VIII, the State had ultimately to make some provision for the sick poor. And at the present day all the hospitals are under the direction and control of an Administrative Council, and the Prefect of Paris and ultimately the Minister of the Interior, while the necessary funds are supplemented

annually by votes in the budget, a legal power being given to assess patients admitted to a proportion of the cost of maintenance, apportioned to their means.

But such a system could not obviously be adopted in London without great adaptation—in practice, if not in principle. In Sweden the hospitals have been worked on a system which may be better adapted with necessary modifications for acceptance here, bringing the poor-law and voluntary institutions into more intimate connection, though managed by separate governing bodies, and only submitted to a State control so far as necessary to insure a certain unity of system and administration, and especially as regards finance and accountability. A scale of charges is also established, and *all pay something except the really poor.* The first class pay a substantial sum, as now in our paying hospitals; the second pay less, but still a remunerative sum.

Finally, as regards ways and means. The Tudor sovereigns took the ready method of confiscating religious endowments with the one hand, and with the other bestowing a portion of the lands and houses for the maintenance of hospitals and poor houses. Nor did they hesitate, as in the case of St. Bartholomew's, to grant by Charter a *right to levy a rate in a whole parish,* which has quite recently been successfully enforced by the governors of that institution, and a rate was actually levied on the rack rent of the parish of Christ Church after an appeal in Chancery.

Thus, then, we have by ancient usage and prescription, for those who attach great value to such a recommendation, precedent for two of the means of support for the London hospitals, failing endowments or other sources: the re-appropriation of funds already existing in endowments for poor, sick, or charitable purposes, and the levy of a poor or hospital rate in the districts surrounding such hospitals.

If this latter alternative should be thought expedient, in considering such a question it must not be forgotten that it is scarcely an innovation, for the Hospitals Asylum Board has provided of late years some 10,000 beds, the whole expense of which is defrayed out of the poor rates, although the wards are by no means limited to the reception of paupers or the very poor in cases of infectious disease.

How far any State control or State aid for the hospitals now in need, or to be created in the unprovided districts, might have the effect of drying up the sources of voluntary subscriptions and charitable bequests, is of course a very

grave question. The tendency would seem to be in that direction, and if operative to any extent, it would no doubt form a strong argument in favour of increased voluntary efforts to make good existing deficiencies, rather than any State aid to supplement necessary income. These are matters for the consideration of a Royal Commission taken in connection with the great need for some general and improved system of control and administration.

XIV.—*On the same. By* H. Nelson Hardy, *late Surgeon, City of London and East London Dispensary.*

At the conclusion of an elaborate series of papers on hospital management, it can hardly be necessary to do more than enumerate, under half-a-dozen headings, the reasons which lead us to urge that a Royal Commission should be appointed to inquire into the whole subject. And 1st.—*The largeness of the interests involved, and the corresponding magnitude of the evils of defective hospital administration,* seem to demand such an inquiry as could only satisfactorily be conducted by a Commission acting under authority from the Crown. According to hospital reports, something like one million hospital patients are treated annually in London alone. According to the most careful calculations a sum of at least ten millions, (£10,000,000), sterling, is invested in London hospitals, much of it very unprofitably, as in the new St. Thomas's Hospital, for the cost of which eight or ten hospitals of equal size might have been built in parts of London where they would have been far more useful than it has proved to be in its present position, and probably far more healthy than it can ever be. Again, Mr. William Gilbert estimates that the cost of treating insane patients at Bethlem is £20,000 a year more than it would take to treat the same number at a first-class private asylum, and there can be little doubt that this holds good also of the other Royal and endowed hospitals. Thus the average cost per bed per annum in the metropolitan infirmaries is shown by a return to the Local Government Board to be £33, while at

Guy's or St. Bartholomew's it· s about £80. It seems a suitable subject for inquiry to find out whether this difference is due to mere extravagance. One result is that £30,000 contributed on Hospital Sunday would go twice as far for the benefit of patients in the well-appointed infirmaries as it does in the voluntary hospitals. It is notorious, moreover, that the waste of time on the part of those of the working classes who seek relief from their ailments at London hospitals, has become quite out of proportion to any benefit they receive,—four, five, or even six hours being not unfrequently wasted in the outpatient room, or while waiting for medicine, often valueless, and it has become necessary in more than one hospital to set up refreshment rooms in the hospital premises, so as to put a stop to cases of fainting from exhaustion while waiting.

2nd. *The wide difference of opinion which exists, even among those best acquainted with the facts, as to the nature and extent of the reforms needed.* Thus some ten or twelve years ago the great panacea for all hospital abuses was declared to be the multiplication of provident dispensaries. Latterly these have been rather discarded, and the system of paying or self-supporting wards and hospitals has found more favour. A society of medical men who investigated the out-patient system some years ago recommended a threefold reform, viz., that each out-patient should be seen personally by one of the medical or surgical staff, and that no unqualified student be permitted to prescribe—that an officer should be appointed to see that the charity is not abused by persons coming who are able to pay ordinary fees—and that no medicine be given gratuitously, the cost of this latter being estimated at £15,000 a year, and it being often so little valued by the patients as to be emptied out on leaving the hospital. Another medical body which more recently paid attention to this subject advised that the out-patient departments should cease to treat all the petty diseases which now overcrowd them, and become places for consultation on difficult cases. Beyond all these goes the demand for a more radical reform, by separating altogether the hospital work proper, i.e., the treatment of in-patients, from the out-patient work which is alleged to be more suitable for dispensaries, and capable of being better attended to by them.

3rd. *The lack of information in official circles as to even the most elementary facts connected with hospitals,* one

example of which may be given. On the day on which I received an invitation to take part in this Conference, I read in one of the morning papers that Mr. Shaw-Lefevre, M.P., in replying to a deputation with reference to the 'Charitable Trusts Bill, 1883,' spoke as follows—"I have excepted from the provisions of the main clause (of the Bill) * * all charities of which more than half of their income is derived from voluntary subscriptions. *I had thought that this would include all hospitals.* I find, however, that some of the charities represented here are hospitals supported only by foundations and not by voluntary subscriptions. I shall have no objection to exempting hospitals from the clause relating to new schemes, and *certainly as a rule, they require no new schemes for altering the distribution of their funds.*" Were it only for the purpose of disabusing the minds of hon. and right hon. gentlemen of pre-conceived notions such as these, a Commission of Inquiry would be extremely useful, and its superiority as a mode of procedure is shown by the fact that a Committee of the House of Commons would necessarily be chosen from members of that House probably as a rule not more familiar with the mode in which funds are provided for Guy's, St. Bartholomew's, St. Thomas's, and Bethlem Hospitals, than is the right hon. gentleman who has charge of the Charities' Bill of the present Government.

4th. *The independence of the great endowed hospitals, alike of public opinion and of government control, and the ascertained impossibility of gaining a hearing from the only public body which even indirectly controls them—the Court of Aldermen—for the most temperate statement of objection to the present mode of working those hospitals.* About five years ago, in conjunction with Mr. Holmes and other well-known hospital reformers, acting as a committee of the British Medical Association, I drew up a petition for presentation to the Court of Aldermen, a copy of which will be found annexed to this paper, so that all present can form their own opinion as to its moderation, about which, I think, there will not be any very serious difference of opinion. When it had been duly signed and engrossed, the next step was to try and get it presented, but in order to do this the formal signature of an alderman was required, and though several members of our committee made strenuous efforts to obtain this, we were unsuccessful. The refusal to permit its presentation to the Court forms a strong argument in favour of an independent inquiry.

5th. *The arbitrary abuse of power exercised by the governing bodies of hospitals against any members of their medical staffs who have exposed the abuses of the present system, or tried to remedy them, while holding appointments at hospitals.* Dr. Charles Mayo, for instance, was summarily dismissed from St. Bartholomew's Hospital a few years ago for refusing to go through the farce of seeing more than fifty new out-patients every morning, and Dr. Chapman from the Metropolitan Free Hospital, because of his efforts by means of letters in the *Pall Mall Gazette* to promote reforms in his own and other hospitals, while at Guy's the Senior Physician and Senior Surgeon have been practically forced to resign, and it is an open secret in well-informed circles that the irresponsible Treasurer of that charity was prepared to dismiss the whole of the medical and surgical staff if they had not agreed to what he, though not a medical man, thought the best system of nursing for the hospital!

6th, And lastly, *the futility of all efforts to reform even the grossest abuses, hitherto made* whether by (*a*) subscribers to hospital funds, such as the munificent founder of the Jodrell professorship of physiology at University College, who having been in the habit of presenting £100 each to five hospitals every Christmas, offered the whole £500 a year to which ever of the large hospitals should first reform its out-patient department, but was unable to get his offer accepted: (*b*) individual members of the medical staff at Guy's, St. Bartholomew's, the Metropolitan Free, and Soho Square Hospital for Women; (*c*) committees of medical men whether formed specially to promote hospital reform, like that presided over by the late Sir William Fergusson in 1870, or that appointed by the British Medical Association, a body now consisting of eight or nine thousand members; (*d*) the Charity Organisation Society with Sir Charles Trevelyan at its head, which for years had a special committee giving much time and attention to this subject; (*e*) the Hospital Sunday Fund, which at starting gave reason to hope, from the tenor of its first report, that its promoters were fully alive to the evils of the present system, but which has proved to be practically powerless to remedy a single one of them; or (*f*) writers in periodicals and the public press, though these include contributors to the *Westminster* and *Edinburgh Reviews*, the *Quarterly*, *Macmillan's* and *Fraser's Magazines*, the *Lancet*, *Medical Times and Gazette*, and *British Medical Journal*. Among the daily papers it

would be difficult to name two which are more opposed to each other on most topics than the *Standard* and the *Pall Mall Gazette*; it would also be difficult to decide which has rendered the most efficient help in spreading a knowledge of the true condition of hospital administration, and the need for reform. But all has been in vain, or apparently in vain. Facts and figures, arguments, ridicule, medical opinions, opinions non-medical, all might as well, so far as those who are responsible for hospital administration are concerned, have never been uttered.

It is chiefly, if not solely, in the increased financial difficulties, and the threatened bankruptcy, of several unendowed hospitals, that indications are to be seen of the practical effects of just dissatisfaction with the present system of hospital administration. Let any responsible statesman ask himself whether it is wise in the face of such a remarkable concurrence of opinion on the part of publicists varying widely in their style and sentiments, and of benevolent persons deeply interested in the prosperity of hospitals, to permit that just dissatisfaction to grow until the problem for a Commission of Inquiry shall be, how to supply from the public taxes the funds now contributed to hospitals by private liberality.

Appendix to Mr. Nelson Hardy's Paper.

PETITION PREPARED FOR THE COURT OF ALDERMEN.

To the Lord Mayor and Court of Aldermen.

The humble Petition of the undersigned representative members of the British Medical Association.

Humbly Sheweth that,

On behalf of the British Medical Association, we desire to ask the assistance of your Right Worshipful Court in our endeavours to procure a reform of certain abuses which have crept into the administration of the large metropolitan hospitals, particularly as regards their out-patient departments. We need hardly remind you that after the suppression of the "religious houses" by Henry VIII, the care of two of the largest of these hospitals, namely, St. Bartholomew's and St. Thomas's, was specially confided to the authorities of the City in response to the petition of Sir

Richard Gresham, Lord Mayor, who pleaded for the poor, needy, sick, and indigent persons lying in every street, and undertook on the part of the City that if their petition was granted these sick and indigent persons should be "refreshed, maintained, and healed of their diseases, frankly and freely, by physicians, surgeons, and potycaries." We are fully aware that these hospitals have ceased to be so directly under the control of your Right Worshipful Court as they once were [see note at the end of this paper], but we cannot help noticing that whenever any such important step as the election of a Treasurer to one of these Royal Hospitals has to be taken, your influence as forming a large portion of the body of governors has a most important share in deciding the result (as in the recent instance of St. Thomas's Hospital), and we therefore do not suppose that you would desire, if you could, to divest yourselves of all responsibility for the management of these hospitals.

The two errors in the administration of out-patient relief at hospitals to which we desire to draw your attention have arisen, as it seems to us, through a disregard of the undertaking given by Sir Richard Gresham, on the part of the City, that these hospitals should be kept especially for the poor and indigent, and that the patients treated at them should be treated by properly qualified physicians, surgeons, and apothecaries.

The latter of these two points we consider of the utmost practical importance. The popular impression is that hospitals are places where those who are sick or injured have only to apply, in order to obtain the best medical advice and medicines, and where the most skilled physicians and surgeons render their personal assistance to all who apply. However true this may be as regards the in-patients, it is certainly not true with reference to the out-patient department of large hospitals, in which the number of qualified medical men is usually quite inadequate to do any but a small proportion of the work; the inference being that the remainder is done by unqualified students or some other persons not appointed for the purpose.

The system has thus become, to a certain extent, one of deception on the public, the sick being attracted to hospitals by the names of famous physicians and surgeons on their medical staffs, and being treated, when there, too often, we have reason to believe, by students in their second or third year of study, or at least by persons whose names are not before the public.

The loss of time to poor working men and women, caused partly by this inadequacy of the medical staffs, and partly by the indiscriminate admission of all classes who like to apply at these departments, is something almost incredible, four, six, or even eight hours being not unfrequently lost in attendance and waiting for medicines, where two at the utmost ought to be sufficient.

We consider that it is neither creditable to the City of London, nor to our own profession, that such blots as these should remain on the administration of our great medical charities (which, undoubtedly, in spite of them, are doing much useful work), and we therefore ask your assistance in our efforts for their removal.

We most respectfully ask your Right Worshipful Court to use all your legitimate influence, in order to procure a reform of the system described in this petition, and we promise if you should think well to appoint a committee on the subject, to lay before it further evidence.

Signed on behalf of the committee,

T. HOLMES, *Chairman*, London.
M. A. EASON WILKINSON, President of the British Medical Association, Manchester.
A. P. STEWART, M.D., F.R.C.P., London.
ALFRED MEADOWS, M.D., London.
ROBERT J. LEE, London.
JOSEPH ROGERS, M.D., London.
J. FORD ANDERSON, M.D., London.
H. NELSON HARDY, London,

British Medical Association Offices,
36, *Great Queen Street, London,*
November 26th, 1877.

NOTE.

In the year 1836, a committee of the Common Council ordered to be printed a number of *Memoranda, References, and Documents relating to the Royal Hospitals of the City of London*,* from which it appears that in 1548 the Letters Patent granting St. Bartholomew's Hospital to the City were delivered in to the Court of Aldermen, who directed them to be delivered to the Chamberlain. That in 1549 the Court of Aldermen directed all leases of hospital lands to be signed by four governors. That in 1553 the Court of Aldermen appointed three Aldermen and three governors to survey and govern St. Thomas's Hospital. That in 1566 the Court of Aldermen directed the governors of St. Thomas's Hospital, at the charge of the Hospital, to provide a physician to look diligently at all times to the sick poor there. That in 1677 certain governors of Christ's Hospital were admitted and acquainted the Court of Aldermen with the contents of an order made by them, and that in the same year committees of Aldermen were appointed to consider the ancient constitution and practice of admitting governors, and other matters respecting hospitals. That in 1681 a governor of Bridewell and two of St. Bartholomew's were admitted to an audience, and a reference made to

* This interesting record is preserved in the Guildhall Library.

the Presidents of the four hospitals and four Aldermen, to inquire into and examine the ancient method of managing the hospitals. That in 1690, Mr. Tindall appeared before the Court, and proposed to discover several sums of money due to the hospitals of the City.

Discussion.

Dr. Evory Kennedy said that after what had preceded it was unnecessary that he should delay the meeting to discuss the question: Hospitals, *cui bono?* He, however, felt it his imperative duty to ask the question: Hospitals, *cui malo?* He had had been expecting anxiously to hear some allusion made to the diseases produced by hospitals; more especially as it bore a direct relation to the branch of the subject now under discussion; whether a Government inquiry into the state of hospitals should be called for; and he was of opinion that a Government inquiry should be called for—were it merely on that sole question. It was scarcely necessary that the present audience should be reminded of the continuous fatality occuring from hospital gangrene, erysipelas, diffuse inflammation, puerperal fever, trismus nascentium, &c., and other lurking hospital maladies, and these in some of our greatest institutions; or that this class of maladies had been endowed with an especial name, "hospitalism." Fifty years had passed since his mind was first deeply impressed in witnessing the ravages of puerperal fever and trismus nascentium at the great Rotunda Hospital, Dublin, subjects to which the late Dr. Joseph Clarke and Dr. Collins then and afterwards called attention, and pointed out that crowding was the root of this class of diseases. These conclusions were subsequently confirmed when he (Dr. Kennedy) became in responsible charge of that institution, with the conviction that separation and structural hospital improvements were the essential means of preventing hospitalism. Within the last ten years the subject of hospitalism had attracted much attention from the medical profession; especially at the meetings of the British Medical Association, when the late Professor Simpson and himself stood shoulder to shoulder in their efforts to draw attention to the defects that predisposed to, and induced unhealthiness in, hospitals. It was to be hoped that the attention called to the subject had rendered us better acquainted with the cause of hospitalism, yet as regards its continuance it was to be feared that matters remained much the same as they did fifty

years ago. The present time was, therefore, very suitable for referring the subject, with the others already dealt with, to the Government Commission, so that we might look forward to a time when no portion of the millions of money set apart for the benefit and recovery of the sick poor in hospitals should be spent as it now was, perversely, in creating and communicating fatal disease and death to those unfortunate creatures who went to our hospitals for life and succour.

Mr. Malcolm Morris, F.R.C.S., (St. Mary's Hospital) desired to say a few words in favour of the appointment of a Royal Commission to inquire into the condition of the London hospitals. He should confine his remarks to the London hospitals, for of the others he had no knowledge to speak from. The first point was, were the London hospitals suffering or not? He maintained that at the present moment they were seriously suffering from a financial point of view. It was his opinion, and one in which he was supported by great authorities, that the big metropolitian hospitals were being slowly starved to death. That was a bold assertion, but it was absolutely true. One of the real reasons why the large metropolitian hospitals which have not medical schools attached to them were being starved to death was because of the existence of a large number of irresponsible institutions which went by the name of special hospitals. It was no use mincing the matter; the time had now come when Government ought to inquire into this question, otherwise the result would be that the special hospitals would go on flourishing while the original hospitals with their medical schools would die out. Would that be a good thing for the nation? For them, at any rate, as individuals, and he was not speaking as a member of the medical staff of a metropolitan hospital but as a private citizen, it would be a lamentable thing for London to be covered all over with small special hospitals for special diseases, and for the large hospitals to die out. The large hospitals with medical schools attached to them were centres of teaching where medical education was carried on and where the medical men of the future were manufactured. If they killed the goose that laid the golden eggs it stood to reason that they would have no more eggs, and it was well that that fact should be recognised at the present stage of the inquiry, otherwise it might be found out when it was too late. He himself was a director of a special hospital, and it might therefore seem that his remarks were contradictory, but the special hospital to which he belonged was one which could not possibly be incorporated with any other. It was the London Fever Hospital situated in the Liverpool Road, Islington. He was on the board of that hospital as a layman, not as a medical

man. He believed that that charity was doing the greatest amount of philanthropic work of any hospital in London. That hospital had just gone through a great financial crisis which almost cost it its life, and last year it nearly perished for want of funds. Had it not been for the philanthropic exertions of the Prince of Wales and other gentlemen who came to its assistance that hospital in all probability at the time he was speaking would have been *non est*. That event would have been a very great calamity, for no other hospital in London supplied the wants which the London Fever Hospital supplied. Why was it that such an institution could not get subscriptions? Simply because of the existence in various parts of London of small hospitals, each with its little circle of patrons and friends who rallied round it, which were simply starving the larger charities to death. The Conference had certainly established a *primâ facie* case on which to petition Government to grant this Commission. Such a Commission ought to embrace not only hospital management, and financial questions, but it should also take in the whole question of the administration of the poor-law in London. Hospital treatment of disease and poor-law treatment of disease were so intimately connected with one another that it was highly injudicious to separate them, though at the present moment they were absolutely separated. It was a great question, and one peculiarly to be dealt with by a Royal Commission, whether these two should not be combined for the greater utility of each. If, for instance, the poor-law districts of London could be divided so that a certain portion of the patients receiving poor-law relief could be drafted into certain hospitals, we should then hear less of the abuses of the out-patient system, and the real poor would then get the best medical attendance possible. Also the large workhouse infirmaries, which at the present moment were being wasted so far as teaching purposes were concerned, might be brought under the great hospital system, and the patients in them might be utilised for teaching purposes.

Sir Thomas Dyke Acland, Bart., M.P. (Guy's Hospital), said he was not present at that Conference in his capacity as a member of parliament, nor as member for Devonshire, though he could speak of the excellent management of the Devonshire hospitals if that were the proper occasion for doing so. He attended the Conference because he took a deep interest in the medical profession, and what was quite another thing, because he took a deep interest in the English nation, to the welfare of which that profession contributed. He had just heard a paper read, to which, as far as he could possibly do so, he had given his best attention. When

he had obtained at the door the papers which were to be read on that day, that particular paper was, by accident, not amongst them, so that he had not had an opportunity of reading it. That paper contained an elaborately prepared attack upon, amongst others, a hospital of which he had been a governor for forty years, namely, Guy's Hospital. No notice had been given of this attack, and as he had just stated, the paper containing it was not put into his hands together with the others which he had obtained at the door. He was unable to reply fully to that paper in the time allowed to him, or at five minutes' notice; all he could do was to allude to some of the points which had been raised. First he would take the opportunity of saying that he was not prepared to speak either for or against the motion which was then before the Conference. As a general rule, it was better for members of parliament not to take part in passing resolutions upon subjects which were likely to come before them in the legislative chamber. Therefore, he did not intend either to speak or vote upon any resolution dealing with the appointment of a Royal Commission, but merely to reply to the attack made upon the body to which he belonged. It was stated in this paper that the average annual cost per bed in the metropolitan infirmaries was £33, while at Guy's or Bartholomew's it was £80. He was not able to answer that statement without the figures to refer to, but he should be extremely surprised if, when he made the inquiry at Guy's, he found that statement to be correct. He would very much like to know how the account had been made up, whether the same items were included in both estimates, whether it really meant the cost per bed, or what it meant. In its present form it was a very vague statement, and therefore he could not meet it; he could only say that he very much doubted its accuracy as far as it related to Guy's. They had been endeavouring at Guy's to reduce their expenses, inasmuch as they, in common with other landowners, had suffered a reduction of about twenty-five per cent. in their income from rent. The possession of land just now was a very burdensome form of property for a charitable institution. Many persons thought it would be far better if all the landed estates held in mortmain by public bodies were sold, and the charities depended for their income upon invested funds. The governors had therefore been obliged to be very careful in looking after the cost of the various departments. It had been found amongst other things that there was a certain laxity in supplying orders for diet which did not always emanate from the highest medical authorities. This had led to considerable looseness and unnecessary expenditure in the matter of diet, and on that point an economy would be effected, though without the slightest disadvantage to the patient. The question of out-patients was a very important one, and the greatest care was

taken to conduct that matter with economy and efficiency. A conference of persons interested in hospitals had investigated the out-patient system some time ago, and an active part in that inquiry was taken by Mr. Lushington, the treasurer of Guy's Hospital. Mr. Lushington was a man of great experience in public life; he had no personal interest in the hospital beyond that of discharging his duty as treasurer, but he took a very active part in the discussion in that room some years ago. The question as to whether each out-patient should be seen separately by one of the medical or surgical staff had been very carefully considered by a committee of the staff and governors. He did not hesitate to say that in many hospitals there was a great deficiency in not having permanent officers of large experience to discharge some of those duties which might be called for at any hour of the day or night, and which at present were left too much in the hands of young gentlemen who, though they might be called duly qualified practitioners, had not the practical experience of medical men in general practice. Practical experience in such matters was an important element, and was more than a purely educational question. The relation between the curing of the sick and the education of medical students was a very important one, and if a public inquiry ever took place into the medical schools, if people had their attention thoroughly drawn to the relations between the curing of disease and the education of medical men, it would be a lucky thing if there was not a great row. With regard to the alleged waste of time on the part of those of the working classes who sought relief from their ailments at London hospitals, every medical man knew that there were thousands of people in the metropolis who would run anywhere if they thought they could get a dose of physic for nothing. At Guy's the plan had been adopted, as an experiment, of charging each out-patient a small sum, he believed it was threepence, for medicine after the first attendance. The question of dealing with out-patients had often been discussed at Guy's, and the discussion had led to the remark by medical men connected with the school that they deprecated anything which would tend to diminish the amount of practice afforded to young men in the out-patient department. He would pass over what was said about Mr. Shaw-Lefevre, because he thought the reader of the paper must have misunderstood what Mr. Shaw-Lefevre really meant. With regard to the fourth paragraph of the paper, the hospitals could not spend money without the consent of the Charity Commissioners, though it was possible that the powers of those Commissioners might be strengthened. Then with regard to the remarks about the *Pall Mall Gazette* and the senior physician and surgeon of Guy's "being practically forced to resign," and that it was "an open secret in well-informed circles that the irre-

sponsible treasurer of that charity was prepared to dismiss the whole of the medical and surgical staff if they had not agreed to what he, though not a medical man, thought the best system of nursing for the hospital," he would say, firstly, the treasurer was not irresponsible. The governing body of Guy's was settled by Act of Parliament, and the treasurer was responsible to what was called the Court of Committees. The nursing question was fully considered not only by the "irresponsible" treasurer, but by the Court of Committees, of which he (the speaker) was a member, and by the whole body of governors; and all he could say was that both he and a large number of the governors were prepared to take very strong measures indeed, and to go the whole length indicated in the paper if it had been necessary. He was of opinion that journalism had a very great deal to answer for in these matters. With regard to hospitals being controlled by the Court of Aldermen he desired to say that at Guy's they had nothing whatever to with the Aldermen, and the Aldermen had nothing to do with them.

MR. HENRY C. BURDETT, (Seamen's Hospital, Greenwich) said that in relation to the question of a Royal Commission, it must be remembered that the present Conference was the outcome of a considerable amount of discussion in the journals and in the press. The press had done a great deal for hospitals, and was doing a great deal every day. As a late hospital superintendent of fifteen years' experience he could bear testimony, and he was sure the Conference would bear him out, that without the aid of the press, it would have been impossible for the hospitals to live. Sa far as endowed hospitals were concerned they did not need the aid of the press, but the criticisms of the press had done them a great deal of good, because they had brought about, especially in the case of Guy's Hospital, a great alteration in the management, namely the election of two of the medical staff as members of the committee which controlled the nursing. By that means peace and harmony had been restored within the walls of Guy's Hospital, and he considered it a great credit to the press that this result had been effected by its means. The question of a Royal Commission had been before the hospitals, before the public, and various Home Secretaries, for something like eight years. It had been asked for by the medical profession, by the British Medical Association, by the treasurers, managers and governors of hospitals individually and collectively, and by the people themselves who received the benefits of the hospitals, and who were represented by resolutions adopted at public meetings. Sir Thomas Fowell Buxton called attention to the fact that in 1879, a petition had been presented by Sir Sydney Waterlow asking for such a Commission. To-day this Conference was assembled there as representative of all

classes of hospitals throughout the country. He had waited to see whether there would be any opposition to the Royal Commission of Inquiry, and he was curious to know what arguments could be used against it. He had heard none such, and therefore he hoped as one of the results of this Conference that the Home Secretary would at length decide to give a certain amount of attention to this question, and that he would see fit to meet the wishes of all classes of people interested in hospitals, and grant this inquiry for what it might be worth. The inquiry had been asked for not because there was any feeling that Government interference was necessary, nor because there was any desire for Government control, but because the best managed institutions at the present time were powerless to let the public know how well they were managed, and also which were the unworthy charities which they ought not to support. He (the speaker) was there to advocate this Commission in the best interests of the best hospitals of the country, and he ardently hoped that it would be but a short time before such a Commission was issued. To delay its appointment was to injure the best managed hospitals and to increase the abuses attaching to other hospitals. To appoint a Commission of inquiry was to secure the best interests of the suffering poor, by strengthening the hands of the intelligently managed hospitals, and by hastening the time when hospital abuse would cease to be, what it was at present, a curse to the poor, and a reflection upon everybody who was responsible for it.

Mr. H. Nelson Hardy, F.R.C.S., said that Sir Thomas Acland had challenged the accuracy of the statements contained in his paper with regard to the comparative cost of the beds in metropolitan infirmaries and endowed hospitals, and had asked for the sources of his (Mr. Hardy's) information. Those sources consisted of a return made to the President of the Local Government Board, in March of the present year, showing the comparative cost of metropolitan infirmaries. It would be found stated there that the average cost was £33 per bed. It might be put down as £33 per head, but he maintained that it was more accurate to put it down "per bed," because it really meant the amount spent upon the whole number of individuals who occupied that bed during the year, and not the amount spent upon the individual treated in the infirmary. In some of the infirmaries the cost of each bed was £50 per annum, while in others it was as low as £23, but £33 was the average for the whole. With regard to his statement concerning endowed hospitals, he derived his information from a gentleman of the very highest authority on hospital finance; and if he was at liberty to mention his name Sir Thomas Acland would acknowledge his authority to be unsurpassed. He could not mention the gentleman's name

publicly, but would do so privately to Sir Thomas Acland. The authority for his statement concerning Mr. Shaw-Lefevre was the *verbatim* report of that gentleman's words which appeared in the *Daily News*. He was at a loss to see how any reasonable man could challenge the correctness of the statement he had made, and if Mr. Shaw-Lefevre used those words they showed him to be utterly ignorant of the fact that there were hospitals in London which did not subsist upon subscriptions, but which possessed such endowments as rendered them entirely independent of public opinion and Government control. If the language which Mr. Shaw-Lefevre used was capable of any other interpretations than the one he had put upon it, he was willing to admit that he was mistaken. With regard to his statement concerning the Court of Aldermen, Sir Thomas Acland was entirely under a misapprehension. The fourth heading of his paper was in these terms: "the independence of the great endowed hospitals, alike of public opinion and of Government control, and the ascertained impossibility of gaining a hearing from the only public body which even indirectly controls them—the Court of Aldermen—for the most temperate statment of objections to the present mode of working those hospitals." And in the memorial to the Court of Aldermen, the hospitals over which even this indirect control was stated to be exercised were enumerated as St. Bartholomew's and St. Thomas's. The reference to the authority of the Court was therefore strictly limited to those hospitals.

Sir Thomas Acland, M.P., explained that what he wished to convey was that the Court of Aldermen had nothing to do with them at Guy's. He was quite aware that they had some control over St. Thomas's and Bartholomew's. With respect to Mr. Shaw-Lefevre, on looking at the paper again, he thought that that gentleman must have been under some misapprehension.

The Chairman (Mr. Francis S. Powell) in summing up the discussions said that he regarded the present system of managing hospitals and charities by means of voters as little better than a monstrous absurdity. Admission to a hospital or charity was, in many cases, gained through the votes of people who were entirely strangers to each other, who probably knew nothing of the institution, and, from the very nature of the case, were utterly unacquainted with the respective claims of the candidates for admission. He hoped we should soon outgrow that folly, just as we had become too experienced to endure many other absurdities in our social system. But if that evil were felt in regard to ordinary charities, it was felt much more with regard to hospitals and infirmaries. The latter institutions ought, above

all others, to be managed by those who from patient labour, self-denial, and careful investigation had become practically experienced in their management. It surely could not conduce to the good working of such institutions, that those experts should be liable to be out voted, and carried away by a flood of voters from outside. He could mention an instance of a vast infirmary in one of the largest cities in the country, built on a most precious site, but hopelessly ill-constructed, which remained on that site contrary to the wishes of the most intelligent of the administrators of the hospital, solely owing to the deluge and hurricane of guinea voters rushing into the room from outside. If that deluge had been absent, if that hurricane had not agitated the atmosphere, instead of one ill-constructed hospital, there would have been several well-constructed, situated in the neighbourhood of the population to whose wants they ministered, and one of these smaller buildings would have been available as a medical school, which the students could have attended without the loss of time and inconvenience which they at present incurred in having to go a considerable distance to this huge massive structure. With reference to governing bodies, care should be taken that there was a sufficient amount of change. According to his experience, however, in this country, there were so many vacancies produced either by incapacitating diseases or absolute death that in many cases a sufficient amount of change was produced; and what he very much deprecated was the carrying away from a public body of useful members just at the time when they had become practically acquainted with the management of the institution. Another requisite which was absolutely essential was that the medical staff should have a seat on the board, or that they should have an absolute right of expressing their opinions before the board. With regard to the question as to whether the medical staff should have a seat on the board or only have a right of speech, his decision would be influenced not by the preference of one over the other, but by the desire to secure that which was most effective for making heard the voice of the medical staff. With regard to that point he would give two illustrations in different directions. In the Yorkshire College of Science, of which he had the honour to be a member, the academic staff were, through their representative, present on the board. They voted, they were always present, and their assistance was of the greatest service to the council in their deliberations and in coming to a decision. On the other hand, in our great schools when they were first reformed there were several schemes at work under which the masters sent representatives to the board; but that method no longer obtained. It was thought to be more in the interests of the masters that they should have as their

spokesman the head master who had the right of audience at the board, but not the right of voting at its meetings. He did not venture to say which was the better of these two courses, but personally he was of opinion that it would be better for the medical staff to have a representative on the board who should have the power of voting. and feel himself in every respect on an entire equality with the other members of the governing body. With regard to the question of finance he had before him the accounts of St. Mary's Hospital. Last year the expenditure was £13,265, the amount contributed from the Sunday Hospital collection was £1,249, which represented the whole of the contributions given by the working men of London to St. Mary's Hospital, and indeed much more, because the largest contributions to the Sunday Fund came from other classes. They had heard that in Glasgow the working men contributed £15,000. In the case of the infirmary of the borough of Wigan, with which he was intimately acquainted, the expenditure last year was £4,000, omitting the odd figures, and of that amount £2,400 was contributed by the working classes. With regard to Bradford the same state of things prevailed some years ago, and still continued, namely, that nearly one half of the amount required to support the fever hospital was contributed by the working men and women of that town. The great contrast between the active energy and liberality of the working men in the north and the miserable apathy of the working classes in London was not to the credit of the great metropolis. In this particular those connected with hospital management had a rich mine of wealth which they had never worked, and the working classes had an opportunity of raising themselves to a position of independence which they had hitherto not made use of. With regard to what Mr. Lloyd had said about Birmingham, and the broad democratic basis upon which such matters were conducted there, he was delighted to hear that remark. He always desired that such Conferences should be thoroughly representative, and felt that that Conference would not have been complete without an expression of democratic views from the town of Birmingham. A remark had been made concerning paying patients, and an instance had been given of a young barrister who was forced to struggle through the hours of sickness as best he could in his own solitary lodgings. He thought that the principle of paying patients might be extended to meet the cases of old gentlemen belonging to the liberal professions, or possessed of sufficient means, who happened to have outlived their generation and their friends and to be cast alone on the strands of life, so as to enable them to find what might be to them a hospitable hotel, or even a kindly home. He would not touch upon the question of provident dispensaries because so much had been said upon that subject, but he wished to make a

remark with reference to out-patients. He was glad to hear that there was some process which was adopted, at least in the provinces, of sifting the applicants for out-patient relief. It would be necessary to sift them not only as regarded their financial condition, but also as regarded their necessity for medical advice. It had often occurred to him with reference to the subject of out-patients, and the contributions of the working classes, that more use might be made of sick and benefit clubs. He did not see why a sick benefit club should not be in some way associated with the local hospital of the district. With regard to medical schools they ought to be looked upon as national institutions and as being of as much importance to the country as the Universities of Oxford, Cambridge, and London. Medical schools were a necessity of the country, though like every other necessity they occasioned some little inconvenience and cost. He did not profess any great knowledge of the subject but he could not help thinking that the presence of medical students was of great advantage to the hospitals. He had been informed by those competent to speak upon the subject that the opinion and criticisms of an intelligent student in the latter period of his education were often of great value to the medical staff of a hospital. If this were so it tended to show that medical schools were as useful to a hospital as they were to the nation of which the hospital formed a part. Before proceeding to say a few words with regard to the subject which was upon all their minds, namely, the appointment of a Royal Commission, he desired to express the great gratification he had experienced in finding that during the two days which had been devoted to able papers, and not less able speeches, that there had been such an absence of anything like ill-feeling. In discussing the question of the necessity for a Royal Commission, it was not necessary for them to rest their case upon accusations against any particular institution. Whatever might be the subject of inquiry there would invariably be found certain conditions present; old institutions had grown up independently, and had worked independently; each one of them had worked on its own lines for the most part in ignorance of what the others were doing, and without the full knowledge of one another's work which frank, free, and unrestrained communication would have given them. It was a matter of history that, as inquiry after inquiry had been made, sometimes by the machinery of a Parliamentary Committee, and sometimes by means of a Royal Commission, to investigate the condition of particular institutions, the most beneficial and wholesome reforms had taken place as the results of that inquiry. The consequence of those reforms had been that although some institutions might perish as being unequal to the demands of the times, and not strong enough to bear reform, yet, for the

most part they had risen from the inquiry improved and reformed, and what was even better, strengthened and made more effective. They had received new vigour, and derived a longer life from that very investigation which, in the first instance, was by no means popular amongst them. Whether such would be the case with reference to the institutions they had been discussing, he was unable to say, but during the two days of the Conference, during which he had listened most attentively to what had been said, he had not heard a single word of objection to a Royal Commission from any of those who were on the committees of the hospitals, and it might therefore be taken for granted that the managing bodies of those institutions were not averse to a Royal Commission. It should be remembered that the managers of London hospitals and infirmaries had not discovered the existence of that Conference from the newspapers, or heard of it by accident. They had all been informed of the intention to hold it, and received an invitation to attend. The Conference was therefore entitled to assume that those who had spoken were representatives of the whole, and from the fact that no speaker had offered any objection to the proposal it might be inferred, perhaps not absolutely and legally, but certainly morally, that there was no great objection, if indeed any at all, to the appointment of the Royal Commission which it was the object of the Conference to set on foot. The work which this Royal Commission would do would be the investigation of the best constitution for the governing bodies, directing especial attention to a fair representation of the medical staff on those bodies. It would collect and publish the information which had been obtained on many points, particularly as to the diversity or uniformity of practice which prevailed. It would discover what reforms were, in general, required, and how those reforms could best be effected. It would suggest the best means of dealing with what appeared to be one of the greatest difficulties, namely, the question of out-patients. It would, no doubt, offer suggestions of great value as to our medical schools, and we might also learn from it something of which less had been learnt at the Conference than he expected, namely, the question of special hospitals, and would no doubt give recommendations as to the desirableness of multiplying the extent of those institutions. Something would, no doubt, occur in its report as to the question of convalescent institutions; how far they should be independent of any local hospital, and how far they should be in conection with the local hospitals of the urban districts. Lastly would come the great question as to how the hospitals of London and the provinces could be relieved of that great burden of debt which appeared to be growing both in magnitude and in weight, and which threatened, if active steps

were not taken, to crush out and destroy some most valuable and beneficent institutions. He concluded by thanking those ladies and gentlemen who had attended and taken part in the discussion, particularly the readers of the papers. When the proceedings of the Conference were published, those papers would become a text-book upon the subjects which had occupied their attention, and would be regarded as a repertory of the latest and best information wherein might be found the best and most mature thoughts of our most advanced thinkers upon those great subjects.

On the motion of Dr. Gilbart-Smith, seconded by Dr. Seaton, the following resolution was then put to the Conference and carried unanimously:—

That the Council of the Social Science Association be requested to invite the following attendants at this Conference to form themselves into a Committee, with power to add to their number, to consider what steps, if any, should be taken to secure combined action among hospitals, and to decide as to future Conferences, and to take such other steps as may appear desirable:—

The Earl of Cork and Orrery, K.P. (St. George's Hospital).
Viscount Powerscourt, K.P. (Ireland).
Sir Thomas Fowell Buxton, Bart., (London Hospital: *Chairman of the Conference*).
H. W. D. Acland, Esq., M.D., D.C.L., F.R.S., (Oxford University).
J. S. Bristowe, Esq., M.D., F.R.S., (St. Thomas's Hospital).
Henry C. Burdett, Esq., (Seamen's Hospital and Home Hospitals Association).
The Rev. Canon Erskine Clark, M.A., (Bolingbroke House Pay Hospital).
R. Farquharson, Esq., M.D., M.P. (Scotland).
S. Leigh Gregson, Esq., (Southern Hospital, Liverpool).
J. J. Gurney, Esq., (Infirmary, Newcastle).
Timothy Holmes, Esq., F R.C.S., (Provident Dispensaries).
G. B. Lloyd, Esq., J.P., (General Hospital, Birmingham).
Francis S. Powell, Esq., (*Chairman of the Conference*).
Joseph White, Esq., F.R.C.S., (General Hospital, Nottingham).

A vote of thanks to Mr. Powell for his conduct in the chair on this the second day of the Conference, proposed by Sir Thomas Acland, M.P., and seconded by the Hon. Dudley F. Fortescue, brought the proceedings to a close.

APPENDICES.

APPENDIX A.

Paper on the Relation of Workhouse Infirmaries to our Hospital System. *By* THOMAS M. DOLAN, L.R.C.P., F.R.C.S. ED.*

A Conference on hospitalism would in my opinion be incomplete without a consideration of the scope of, and work done by, our poor-law infirmaries.

The general voluntary hospitals in the metropolis accommodate but a small portion of our sick; thus only a fringe of the great misery of London is touched.

The same is true of the provinces.

The voluntary hospitals are fewer in number, and accommodate a smaller number than the poor-law infirmaries. A few figures will at once make this clear.

At the Social Science Congress, Nottingham, 1882, Dr. Gilbart-Smith read a paper on hospital administration. In the published report of his paper in the Transactions† are to be found tables on the accommodation afforded by all the London hospitals.

According to these tables the twenty general voluntary hospitals contain 4,860 beds, while the special hospitals afford accommodation for 3,100 patients. In contrast with this I find the metropolitan pauper infirmary accommodation amounts to 10,094, while the poor law-sick Asylums support 1,474 inmates.

These returns differ materially from those furnished by the Lancet Commissioners‡ in 1865, when the 18 London

* This paper is inserted here, the limited time at the disposal of the Conference not having permitted of its being included in the published programme.—ED.

† Transactions, etc. Nottingham, 1882, p. 431.

‡ Lancet report, etc., 1865, p. 10.

hospitals provided 3,738 beds, but the metropolitan workhouses found beds for 7,463 sick, and nominally for about 7,000 infirm. It was this fact which induced the Lancet Commissioners to make the following statement:

"Foreigners coming over here are not slow to discover that the public hospitals of London, of which we boast so much, accommodate but a small portion of the sick. The State hospitals are in workhouse wards. . . . It is upon the wide field, far wider even than that afforded by our noble voluntary hospitals, which is presented by the great infirmaries of our workhouses, that many a problem of deep and vital importance to the health and happiness of society must be worked out."

The *Lancet* Commission has undoubtedly caused a great reformation in our workhouse hospitals. They no longer contravene the rules of hygiene; and the guardians of most English unions have acknowledged the truth of the declaration issued by the *Lancet*:

"That the sick poor in workhouse infirmaries have a right to the same advantages of pure air, good baths, efficient ward arrangements, and skilled nursing as are supplied to the inmates of voluntary hospitals."

England is now studded with magnificent institutions for the sick poor. Unfortunately the *Lancet* programme has not been carried out in full, for we cannot say that all guardians supply sufficient and unfettered medical attendance.

There is much yet to be done, though we have to congratulate ourselves on the progress which has been made.

Misconception prevails as to the class of persons found in workhouse wards. They are filled with a very different class from the one for which they were originally intended. Our patients are not composed *in toto* of the improvident, the dissolute, the extravagant, or the vicious. The majority are the victims of circumstances, deserving poor whom illness alone has led on the downward step to pauperism. Thus we find in our wards the pension-less discharged soldier, with aortic aneurism; the would-be thrifty mechanic with phthisis, the baker bronchitic from the result of his employment; the out-door labourer with rheumatism or pneumonia, the sequence of exposure to cold or wet; the domestic servant with uterine disease; the overworked operative with paralysis in some of its forms; in a word, representatives of all trades and classes suffering from various diseases which have prevented them from earning a living—when private resources

and charity have been exhausted, they have been compelled to seek the haven of the union infirmary.*

It may be alleged that a large number of those mentioned are past all hope of recovery, but there are a far larger number who by medical attention and nursing might be restored to health, and thus be placed again in a position to earn their own livelihood, to the consequent saving of the rates.

The name workhouse is a misnomer. In the majority of towns the so-called workhouses are large hospitals supplementing the subscription general hospital. In many towns they supply the major part of the hospital accommodation.

Oppert in his work on hospitals † lays down the rule that a town of 50,000 inhabitants need not have a hospital for more than 150 patients, providing there is a Union infirmary with 50 beds.

The inverse ratio generally exists, the voluntary hospital making up the smaller number, the union the larger number of beds.

Thus for instance the Halifax Infirmary has accommodation for 70 patients, the union infirmaries for 312.

If Oppert's rule be the true one, we have here a violation of it, and not by any means a singular one. The same state of things is to be found in nearly all our English towns.

I think there can be little disagreement about the first point to which I wish to direct attention, viz : that the poor man's hospital is the Union infirmary, and that the major accommodation for the sick poor in England is provided by the Union infirmaries.

It is a large question upon which I cannot now enter, as to the cause why such a number seek medical relief in workhouse hospitals,‡ but as it is a fact that there are such a large number of applicants for this form of medical relief, it is well worthy of attention and consideration how this medical assistance can be best rendered, how the existing hospitals should be conducted, how managed : how best to promote the ultimate ends for which all hospitals really exist,

* See " Some remarks on workhouse hospitals, with illustrative cases," by T. M. Dolan, F.R.C.S., Ed., Goodall, Leeds, 1879.

† Oppert, on hospitals, etc., 1867, p. 4.

‡ See " Lancet Report," or any of publications mentioned in Bibliography.

viz: the cure of disease and the alleviation of human suffering.

It is a truism to say that pauperism is largely the outcome of sickness. It is the greatest factor in the production of what we term paupers, a name which carries with it some degree of reproach.

With the altered circumstances under which workhouse infirmaries now carry on their work, there ought not to be any reproach that the old and destitute should seek a home and comfort, provided by the State, to which they have themselves contributed, when in health, by the payment of rates, or that the labourer, operative, mechanic, servant, should in periods of sickness avail themselves of their parish infirmaries.

To my mind it is less derogatory for a workman to accept the services and medical aid of a poor-law institution, to the support of which he has himself been a contributor, than for the same workman to beg or solicit a ticket from a subscriber to a voluntary hospital, and there have to receive eleemosynary aid supplied by the benevolence and charity of a few private individuals.

In the one case he accepts State aid to which he has a right, in the other he places himself under an obligation to persons on whom he has no claim. I even contend that as regards his self-respect the alternative between the Union infirmary and the voluntary hospital turns in favour of the former.

I agree with Ruskin,* "A labourer serves his country with his spade, just as a man in the middle ranks of life with sword, pen, or lancet. If the service be less, and therefore the wages during health less, then the reward when health is broken may be less but not less honourable: and it ought to be quite as natural and straightforward a matter for a labourer to take his pension from his parish, because he has deserved well of his parish, as for a man in higher rank to take his pension from his country because he has deserved well of his country."

This statement, though not universally believed in, and though it may sound strange, is logical and true, but like all truths it takes a time to impress it upon the hearts of the nation. We partially believe in it at present; we make provision by means of workhouse infirmaries for the larger number of the sick poor of England, and we have built up a semblance of a hospital system.

* Ruskin's "Unto this Last." Preface.

In London poor-law administration has reached such a level that it would seem as if the London guardians had grasped the truth, that the state paupers when sick should be treated in the same maner as the *voluntary paupers* who seek the aid of the voluntary hospitals. I trust the time will come when it will be considered neither degrading or dishonorable for the sick poor to enter the London poor-law sick asylums, just as it is now neither degrading or dishonorable for patients to enter the London hospitals.

I shall presently speak of the relation of the London poor-law sick asylums to medical education, but I must now return to the condition of provincial poor-law infirmaries.

As regards building arrangements and general architectural details the poor-law guardians throughout the country have realised some of the elementary truths as to the the requirements of hospitalism. The majority of modern poor-law union infirmaries are admirably adapted for the treatment of disease; they fail, however, as regards the *personnel*, in management and officers. I can best illustrate this by comparing the staff of the Halifax infirmary with that of the union infirmary.

The Halifax infirmary has accommodation for 70 patients. It is well and ably officered, it has a house surgeon, an assistant house surgeon, two consulting surgeons, two visiting physicians, four visiting surgeons.

In striking contrast with the excellent medical provision made at the voluntary hospital is that of my own infirmary.

The union infirmary has 312 beds. I am the only medical officer, and I am not resident. I have to act as physician, surgeon, accoucheur, and dispenser.

The guardians are most liberal in providing for me every medical and surgical appliance, and I have to thank them for rendering my duties easier by their ready compliance with all my suggestions. Our infirmaries may fairly vie with any voluntary hospital, as regards construction, ward arrangements, furniture, etc. It is only weak in its medical staff.

The patient who accepts aid from the voluntary infirmary, if he is fortunate enough to secure admittance, has the advantage of advice from many sources, whilst another poor man unable to be admitted, perhaps from want of room, has to seek advice at, and admission to, the union infirmaries where he can only have the aid of one.

The class of persons who enter the Halifax infirmary are much the same as those who enter the Union; in fact I have at the present moment a number who have been in the infirmary and who have had to leave, simply because their cases took too long for treatment.

The medical arrangements at the Halifax Union infirmaries are similar to those in most towns. There is generally one visiting surgeon. Leeds, Manchester, Liverpool, I am glad to say are differently officered. These Union infirmaries' have resident and assistant surgeons, with consulting surgeons and physicians to give the benefit of their advice, and assist in the treatment.

Again, the nursing arrangements at our voluntary hospitals are better than those in poor-houses. In the majority of the latter there are a few paid nurses, who are assisted in their work by pauper helps, wardsmen and women, who have had no special training for the important duties they have to perform, viz.: that of nursing the sick. All who are familiar with the excellent work done by Miss Louisa Twining for the promotion of trained nurses in workhouses, will admit the evils of the present system, and the importance of remedying it.*

In the metropolis the efforts of those ladies who have taken up the cause of workhouse reform have been crowned with success.

The metropolitan sick asylums in whatever way we consider them, whether in an economical, a social, a philanthropic, or a medical aspect, must be pronounced a success so far as they have gone.

The extension of the same system into the provinces, at Leeds, Liverpool, Birmingham and Manchester, affords us a hope that the whole poor-law system of infirmaries will be placed on a uniform basis.

I shall briefly summarize some of the requirements :—

(*a*) All poor-law infirmaries should have an adequate staff of medical officers, who should not be required to find the medicines, and who, subject to the control of the visiting committees, should have the management of the nursing, &c.

(*b*). There should be resident superintendent medical officers for all infirmaries, affording accommodation for a large number of patients. What that number shall be I shall leave to the decision of the Conference.

* Vide Reports of Association for providing trained nurses in workhouses. May be obtained from Miss L. Twining, Queen's-square, London.

(*c*) There should be consulting medical officers to assist in operations and in general treatment.

(*d*) There should be a proper system of dispensing medicines by qualified dispensers.

(*e*) Trained and paid nurses only should be employed.

(*f*) There should be proper classification of the sick into medical, surgical, acute and chronic, with special wards for children and lying-in women.

(*g*) In the interests of humanity, the medical officers of workhouses should have, under suitable restrictions, the power of making *post mortem* examinations.

(*h*) Finally workhouse infirmaries should be conducted on the best principles of hospitalism and should be made as efficient as the general voluntary hospitals.

All these suggestions are based on my belief and my practical experience, in which I think I shall be supported by all intelligent medical officers in the poor-law service, that our infirmaries are not filled with vagrants, ne'er do wells, the dissolute and the improvident, veritable paupers who have been invalided, but by sick persons who are pauperised by their sickness.

As the *Lancet** points out, there is an important economic distinction between the two classes of possible inmates specified.

The purpose and scope of an infirmary attached to a poor-law district in modern times are very different both from what they were in past times and from the popular conception of it.

The infirmaries or wards for the sick attached to workhouses are not provided simply for the medical paupers who may fall ill in the workhouse; if that were the case the duties of the medical officer would be very slight indeed.

The union infirmaries must be viewed as hospitals for the districts with which they are connected; the poor-law system contemplates something more than the relief of sick paupers, and includes in its programme an attempt to cure the maladies which contribute to the increase of pauperism by disabling and throwing upon the rates the poor who may fall sick, and not unfrequently their families also.

I think it must be clear to all who are acquainted with our poor-law system and its working in modern times that the State in sanctioning such an enormous expenditure

* *Lancet*, Vol. I., 1880, p. 651.

on workhouse infirmaries throughout the kingdom contemplated making public provision for the sick poor.

It is officially engaged in hospital work. It has raised the standard of treatment of the sick poor in the metropolis, and the State has been aided in this by the active and intelligent co-operation of the metropolitan poor-law guardians.

With the existing machinery and net work of hospitals spread over the whole country, there ought not to be any difficulty in providing for the sick poor.

Whether we look upon the interests involved from the side of the ratepayers, the guardians, the patients, or the medical officers, it seems to me beyond all dispute that the application of the best principles of hospitals in our workhouse infirmaries is both justified and demanded, as we thereby secure true economy for the ratepayers and guardians, the best chances of recovery for the patients, and justice for the efforts of their medical attendants.

The position of workhouse infirmaries is deeply interesting in another aspect, viz., in its relation to medical education. In 1865 the Lancet Commissioners * well and truly said: "with proper management what magnificent clinical hospitals might our workhouse infirmaries become, and how greatly would the patients benefit from the attendance of students with sharp prying eyes."

And, again, in 1880, *The Lancet* † writes:—"The amount of clinical material in these institutions must be very large; it is a pity on scientific grounds alone that this should be sacrificed. All who have given attention to this subject of union infirmaries must know that the field for medical observation and study in these hospitals is unrivalled."

Those who have had opportunities of judging are agreed that medical education would benefit by throwing open these infirmaries to students.

In the *New Quarterly Magazine*, Nov., 1875, there is a very good article entitled "Workhouse visiting and management during twenty-five years." The writer suggests that these institutions should be open to medical students for the clinical study of disease. On this proposal Mr. Samuel Benton thus expresses himself: "If this change were effected it would not only be advantageous to the sick poor,

* Report of Commission, p. 10.

† *The Lancet*, 1880, Vol. I., p. 652.

but would also make these institutions serviceable for the study of disease, and indirectly a benefit to the public."

These sick infirmaries are full of cases which are met with in private practice, but are never seen at a hospital. The field for pathological study in these places can be best realised by a glance at the Pathological and other medical Societies' Reports for the past few years.*

A London physician, Dr. Th. S. Dowse, with a full appreciation of the great field of study opened out by the London sick asylums, followed up Mr. Benton's letter with words of approval. Dr. Dowse† writes: "I should like to supplement Mr. Benton's well-timed observations by a few words of approval, and I want to know how this question can receive practical consideration . . . . I consider the whole question of such great importance that I would suggest with the most serious earnestness that it be brought before the consideration of the Medical Council . . . . . If the wards of these splendid institutions were thrown open every morning from ten to twelve a.m. an enormous amount of good work could be accomplished."

Dr. Gilbart-Smith,‡ at the Social Science Congress, at Nottingham, 1882, thus expresses himself on the *rôle* of our poor-law hospitals: "The admission of the students of general hospitals to the poor-law infirmaries would likewise present a larger number of patients in proportion to the number of students. The Metropolitan County Branch of the British Medical Association, when discussing this subject last year, arrived at the conclusion that the workhouse infirmaries as at present administered do not render such service to medical education and science as they might. These institutions offer a splendid field for the treatment and investigation of disease, for pathological research, and medical education. By the appointment of visiting physicians and surgeons assisted by efficient juniors and aided by a staff of clinical clerks, dressers, sisters, and nurses, the inmates would reap the direct advantage of improved arrangements, while medical education would gain from the scientific observations afforded by the large number of sick congregated together in these institutions, consisting more especially of forms of disease rarely admitted into

* *The Lancet*, 1879, Nov. 8th, p. 709.

† *The Lancet*, 1879, Nov. 8th, p. 785.

‡ Trans. Social Science Congress, Nottingham, 1882, *loc. cit.*

general hospitals; and obstetrical teaching, a department now most defective as regards practical instruction, would be immensely benefited."

I need not quote any other authorities to drive home the truth that medical education might be advanced by the utilization of our poor-law institutions. I trust this will be at once conceded.

The question narrows itself down. How can they be utilized? What provision should be made so as to secure the attendance of students and at the same time prevent any interference with the internal management?

There are always difficulties to be overcome in the elaboration of useful schemes.

There are not any formidable difficulties in the way of bringing about an arrangement between the authorities interested in medical teaching and the authorities who have the control of our poor-law sick asylums.

When the truer *rôle* of poor-law infirmaries is fully recognized, when their importance as regards the cure of the sick and their value as teaching media become more fully appreciated, when many trying restrictions are removed, these institutions will attract a more scientific and perhaps a higher class of medical officers.

The possibilities of the future of poor-law infirmaries may be gathered from what has been done in our poor-law lunatic asylums. The interests involved are the same as far as regards the class of patients. The pauper in the asylum to-day may be in the workhouse to-morrow and *vice versa*. Our pauper lunatic asylums occupy an unrivalled position in the general and medical world. Asylum medical superintendents have made their appointments not only respectable but honourable, by their zeal, energy, tact, and scientific use of the diseased patients over whom they are placed. It must not be forgotten that they have been assisted and encouraged in their work by the managers of our lunatic asylums.

The elevation of the poor-law medical service must come when poor-law managers grasp the principles I have endeavoured to lay down in this paper.

Under many difficulties in the past the poor-law medical service have endeavoured to do their duty, in many cases it has been up hill work and a continual striving against prejudice and ignorance.

Should the consummation I so much desire be reached, viz.

that our workhouse infirmaries should take their place in relation to our hospital system, we may feel certain that the poor-law medical service will be stimulated to increased exertions and will gain for itself a reputation equal to that now enjoyed by that branch of the service devoted to the treatment of mental diseases.

The solution of the difficulties at present attending our hospital system may be found in the hitherto despised parish infirmaries. The conclusions at which I have arrived are :—

1. The voluntary hospitals should extend the pay system, by opening their wards to the large class who, with limited incomes, are able and willing to pay a proportionate rate for medical attendance, nursing and support.

2. The special hospitals, which absorb such a large amount of he public's charitable donations, should, save in a few instances, be closed.

3. The voluntary hospitals, especially the out-patient departments, should, as far as possible, be conducted on provident principles ; thus, the working classes would be able to obtain high class medical advice at a moderate price.

4. All surgical cases requiring high class operative skill should be admitted to the general hospitals.

5. The existing union infirmaries should be affiliated to, or amalgamated with, the general hospitals ; the residium of the sick poor would be thus amply provided for. We should then have a system somewhat resembling the French system, though with a modification. The State would have control of the parish infirmaries, while at the same time voluntary charity would find an outlet in the management and support of the general hospitals.

The details of such a scheme would have to be worked out and elaborated.

Many points would have to be considered as to the management, the medical staff, nursing, source of income and incidence of same, etc. I do not see any difficulty in satisfactorily arranging all the details. When we consider the state of workhouse hospitals in 1865, when the "Lancet" Commision was first formed, and compare it with the present condition of our union hospitals throughout the kingdom, there is every ground for hoping that the union infirmaries will occupy in the future a higher *rôle*. This will be secured when they are placed in their proper relation to our general hospitals.

BIBLIOGRAPHY.

1. "The Lancet Sanitary Commission," London, 1865.
2. "Workhouse Infirmary Reform," by Dr. Anstie. Macmillan's Magazine, Vol. xiii. 1866, p. 477.

3. "The Workhouse." St. Paul's Magazine, vol. xii., p. 70, 1871.
4. "The Management of Workhouses." By S. W. North, Trans. Soc. Sci. Assoc., Manchester, 1866.
5. "Destitute Incurables in Workhouses." Miss Elliott, Miss Cobb.
6. "A few words about the inmates of our Workhouses," 1855. Longmans.
7. "Metropolitan Workhouses and their inmates." Longmans, 1857.
8. "Workhouse visiting and management during the last 25 years." Miss L. Twining. New Quarterly Mag. 1879.
9. "The young women in our Workhouses." Mr. Barnett, Macmillan's Magazine, vol. 40, 1879, p. 133.
10. "Workhouse infirmaries." Stanley Lane-Poole, Macmillan's Magazine, vol. 44, 1881, p. 219.
11. "Workhouses and women's work." Church of England Monthly Review, 1856.
12. "A Letter to the President of the Poor Law Board on Workhouse Infirmaries." Miss L. Twining. London: Hunt and Co., 1856.
13. Report of Mr. Farnell, and Dr. Edward Smith, 1865.
14. Mr. E. Hart, Fortnightly Review, 1867.
15. "Report of Select Committee on Poor Relief" (England). 1861.
16. "Workhouse Girls, what they are, and how to help them." Miss Joanna M. Hill. Macmillan's Magazine, vol. 28, 1873, p. 132.
17. "Workhouse System." Blackwood's. Vol. 41. p. 83.
18. "Workhouses in London.' Good Words. Vol. 15, p. 769.
19. "Workhouse Management." Vol. 58. p. 5. Chambers' Journal.

APPENDIX B.

THE FOLLOWING IS THE MEMORIAL OF THE COUNCIL PRAYING FOR A ROYAL COMMISSION OF INQUIRY, PRESENTED TO THE HOME SECRETARY IN MAY, 1882, AND ALLUDED TO ON PAGE 6.

To the Right Honourable Sir William Vernon Harcourt, MP., Her Majesty's Secretary of State for the Home Department.

The Memorial of the Council of the National Association for the Promotion of Social Science.

SHEWETH:—

1. That your Memorialists have had their attention directed to the question of the administration of Metropolitan Hospitals, and the other Institutions for the medical treatment of the sick, and have, by public discussions held under the auspices of the Association, in which those well qualified from their position and

experience to join have taken part, and by other modes of inquiry, arrived at the conclusion that reforms are desirable in the existing system of administration.

2. That your memorialists have agreed upon the following resolutions .—

I.—That the Hospital accomodation of London is imperfectly distributed, and, in many districts, altogether inadequate.

II,—That the want of organisation and co-operation among the medical Institutions of the Metropolis materially lessens their usefulness and leads to unnecessary expense.

III.—That the present system of indiscriminate relief injuriously affects the independence and self-reliance of those who are able to meet, in some degree at least, the cost of medical and surgical treatment.

IV.—That the funds at present available, either for proper maintenance of nearly all the existing Institutions, or for the extension of relief to districts hitherto unprovided for, are very insufficient.

V.—That the Hospitals are managed (some of them under Acts of Parliament) on very different systems, and some of these systems can hardly be worked consistently with the advance which has been made in medical science, and with the change of opinion which is taking place regarding the administration of medical charity.

VI.—That it is desirable to make more use than is at present made, in the education of medical students, of the materials contained in the numerous Hospitals and Dispensaries now administered by the Poor Law Department and the Metropolitan Asylums Board, and that there should be more intimate communication between these and the General Hospitals.

VII.—That the operation and constitution of the numerous special Hospitals and Dispensaries demand inquiry, in order to inform the public as to the advantages and disadvantages of such Institutions.

VIII.—That it is desirable that a uniform system should be devised and adopted of keeping the books of accounts and registers of diseases in all Hospitals.

3. That your Memorialists, whilst anxious to disavow the intention of adopting any recommendation in favour of compulsory Government control or management of voluntary Hospitals, are not less desirous of expressing their opinion that a favourable time has now come for the institution of a full and impartial

inquiry into the accommodation afforded by, and the present system of the management and administration of, the Metropolitan Hospitals and the other Institutions for the medical treatment of the sick.

4. That your Memorialists venture to accompany this Memorial with a Statement of some of the reasons on which the above Resolutions have been based.

Your Memorialists, therefore, humbly pray that Her Majesty may be pleased to issue a Royal Commission to ascertain fully the needs of the Metropolis in the above respects, with a view to obtain reliable data upon which to base such reforms as may be necessary, and to make such recommendations as may appear to it desirable.

And your Memorialists, &c.

EXPLANATORY MEMORANDUM, SETTING FORTH SOME OF THE REASONS ON WHICH THE EIGHT RESOLUTIONS CONTAINED IN THE MEMORIAL HAVE BEEN BASED.

No. 1—*That the Hospital accommodation of London is imperfectly distributed, and, in many districts, altogether inadequate.*

The population of London, resident in the area which is served by the Metropolitan Charities, is estimated at 4½ millions, exclusive of the population of the adjacent counties, from which, however, many severe and difficult cases are frequently sent to the London Hospitals. Of this large number, the upper classes are able to procure good medical advice for themselves; the lower or pauper class are sufficiently provided for by the Workhouse Dispensaries and Infirmaries; the intermediate class, including labourers, artizans and small tradesmen, are accustomed to resort in cases of severe illness or accident to the charitable medical Institutions. The number of Metropolitan Hospitals is about 60, and their aggregate average gross income is about £572,000, partly derived from endowments, and partly from voluntary donations and bequests. But, notwithstanding this provision, there are great and populous districts, covering many square miles, which are without any adequate provision for the Hospital treatment of patients. The general Hospitals, including all the very large ones, are clustered round the centre of London, whilst there are few, and those of small capacity, in the outskirts, occupied principally by a dense labouring and lower-middle-class popu-

lation. Of fifteen general Hospitals, exclusive of the French, German, Seaman's and Homœopathic, ten (see Table A) are within a radius of a mile and a-half of Charing Cross, and contain 3,439 beds out of a total of 4,334 for the whole Metropolis. Of the other five, one only—the Great Northern, with 33 beds—is situated in North London to meet the requirements of a population estimated at 908,000; two—the London with 790 beds, and the Metropolitan Free with 20 beds, (both in the extreme West of the district beyond the City)—are alone available for the East End with its river-side and manufacturing population of 1,041,000; two in the West—St. Mary's, 190 beds, and West London, 42 beds—remain for a population of 912,000. On the Surrey side of London there are two (both of which are included in the ten above mentioned)—Guy's with 630 beds, and St. Thomas's with 572 (of which latter, however, only 430 are at present available) for a population of 1,380,000. Both these Hospitals are situated in the extreme North of the district South of the Thames, and, therefore, are at some miles distance from a portion of that district.

In short, North London has no large general Hospital, and the extreme East, West, and South are scarcely better supplied.

There is no sufficient provision for those ailments which require pure air or special appliances for their proper treatment. There is no machinery for meeting the requirements caused by the annual growth of London.

For a proof of these statements reference is requested to the accompanying Map, which shows how the various Hospitals are distributed.

No 2.—That the want of organisation and co-operation among the Medical Institutions of the Metropolis materially lessens their usefulness and leads to unnecessary expense.

Each medical Charity, as at present constituted, is managed by its own Committee or Board. There is no unity or uniformity of action, nor co-operation between different Institutions; nor any uniformity of system in the administration. Hospitals and Dispensaries are erected according to the special views or convenience of the Managers or Founders, not where they are most urgently required. In some Institutions there is excessive expenditure or other mismanagement. The most serious consequence of the want of organisation is, perhaps, the impossibility, except in isolated Charities, of abolishing the vicious and pauperising features of gratuitous medical relief, and establishing a provident system under which both in and out-patients might pay a portion at least of the cost of their treatment, unless they preferred to claim the exemption of paupers

It is suggested that if the Dispensaries in any given district were affiliated to the general Hospitals, the over-taxed out-patient departments of the Hospitals would be lightened, and the growth of the provident system would be greatly encouraged. Such an arrangement would also afford to the Medical Schools a good opportunity of supplying a deficiency in their present education, by appointing well-qualified young men, after the completion of their Hospital training, to be assistant Physicians or Surgeons of a Dispensary.

No. 3.—That the present system of indiscriminate relief injuriously affects the independence and self-reliance of those who are able to meet, in some degree at least, the cost of medical and surgical treatment.

With regard to this, there cannot, it is thought, be any great difference of opinion. The pauperisation of the working and industrial classes is more or less inevitable under any system of indiscriminate bounty, and constitutes one of the most serious defects of the present system, inseparable as it is from such a multiplication of medical Charities scattered over London, without any unity of action or adequate means of avoiding undesirable divergencies. It is the labouring, industrial, and wage-receiving part of the population which occupy the wards and out-patient rooms of Hospitals and Dispensaries. How far the class in question are properly entitled to receive medical treatment as a charity, or in what manner those who are able should contribute some portion or the whole of the costs, is precisely one of the questions which it would fitly devolve upon a Royal Commission to ascertain by careful inquiry. But all must feel that it is impossible to ignore the sympathy which the benevolent will always cherish towards their poorer brethren, who, although ordinarily in receipt of good wages, are temporarily deprived of the means of supporting their families.

No. 4.—That the funds at present available, either for proper maintenance of nearly all the existing Institutions, or for the extension of relief to districts hitherto unprovided for, are very insufficient.

A large proportion of the medical Charities of London are dependent, wholly or in part, on the precarious and insufficient income derived from voluntary contributions; and their efficiency is to a great extent impaired, and their development cramped, for want of funds. In some cases it is impossible to maintain the number of patients for which the building is adapted. The newspapers are filled daily with urgent appeals

for assistance, to enable the work to be efficiently carried on, and for the discharge of accumulated liabilities. Indeed, the day may, not improbably, come, when from the falling off of the present casual support, the closing of a considerable part, or the whole, of some large Institution may bring misery upon the neighbourhood in which it is situated.

In some cases, the gradual migration of the wealthy classes of a district has deprived the medical Charities in that neighbourhood of the local support which they previously depended upon ; consequently the difficulty of maintaining those Institutions in a state of efficiency increases year by year. The gross income compared with the expenditure, as returned to the Hospital Sunday Fund, shows an annual large excess in the latter, which has, in most cases, to be met by a sale of stock ; and it is feared that such sales are likely to increase rather than diminish.

But perhaps the most urgent need of funds arises from the obvious necessity for a greater number of general Hospitals to meet the wants of an area of 120 square miles, covered by a dense population. In cases of accidents or serious illness, patients are frequently transported several miles to reach one of the general Hospitals, which, with few exceptions, are situated, as has been shown, near the centre of the Metropolis. Several such general Hospitals are required in the outlying districts, while Convalescent Institutions, to which patients may be sent to complete their recovery, and which would at the same time relieve the wards of Hospitals, are also urgently needed. Capital is required to build all these, and income to maintain them afterwards.

A Commission should also report in what way the requisite funds should be provided, whether, partly at any rate, by payment by patients ; and how these payments should be supplemented, together with such other cognate matters as might result in the final adoption of important improvements in the working of the present system of medical relief in London.

No. 5.—That the Hospitals are managed (some of them under Acts of Parliament) on very different systems, and some of these systems can hardly be worked consistently with the advance which has been made in medical science, and with the change of opinion which is taking place regarding the administration of medical charity.

Reference to a work issued by Mr. Burdett, (*Statistical Tables*, published by J. & A. Churchill, new Burlington Street, W.) and based on authentic data, will show that the percentage of the cost of management to that of maintenance in Metropolitan

General Hospitals varies from 27.514 (No. 3) to 5.073) (No. 70*a*), and in Metropolitan Special Hospitals from 55.070 (No. 120) to 3.357 (No. 122); and although very probably much of this variation may be due to different methods of accounting, yet even this matter in itself is one which calls for inquiry. The different systems of management are exhibited in a comparison of the constitution of the governing bodies of the various Hospitals. 1st. At the great endowed Hospitals the governing body is self-elected, and the medical officers have but little, if any, voice in the management. 2nd. At some Hospitals the general body of subscribers delegate their powers to a Committee, of which the medical officers may, or may not be members; while other Hospitals are practically governed by a single individual. 3rd. There are Hospitals where any Governor may attend and vote at the open Board on any question, and where all the medical officers may, and usually do, qualify as Governors.

Another aspect of the differences in systems of administration is in regard to the rules for the reception of patients. Some Hospitals are entirely free; others profess to receive hardly any patients except those recommended by the subscribers. Some receive fever and acute cases, which other Hospitals refuse. The rules for the out-patients differ at almost every Hospital.

Lastly, a question of much importance relative to the successful management of Hospitals is their connection with Medical Schools. An inquiry on this point would show the need for such, for in many instances the Schools are under management independent of that of the Hospitals, and hence, at any moment, circumstances may arise which would interfere with that harmony which is essential to the satisfactory working of the joint Institutions.

No. 6.—That it is desirable to make more use, than is at present made, in the education of Medical Students, of the materials contained in the numerous Hospitals and Dispensaries now administered by the Poor Law Department and the Metropolitan Asylums Board, and that there should be more intimate communication between these and the general Hospitals.

The presence of a body of medical students is a necessity for every large Hospital, and in place of being injurious to the sick, is, on the contrary, an important factor in the economical working of a Hospital, and is a direct aid in the treatment of the patient. This is a matter as important to the wealthy as to the middle and poorer classes, but the School authorities of the unendowed Hospitals are continually thwarted by want of funds

in their endeavours to improve the education. The relations of the great Hospitals to the Medical Schools must always remain an important branch of the subject now under consideration. It is, therefore, most needful to inquire whether any improvement can be effected in these relations. Without touching on more doubtful matters, it may be pointed out that under our present system of Hospital teaching, hardly any use whatever is made of the ample materials for instruction which are to be found in the Poor-law Infirmaries, the Poor-law, the Free and the Provident Dispensaries, the Lunatic Asylums, and the special Hospitals which have sprung up in such numbers of late years. Hence complaints that the students of the present day, though far better grounded in the scientific basis of their profession than formerly, have not sufficient acquaintance with the minor details of every-day practice, which could be easily acquired in visiting Dispensary patients; and that they are apt to neglect many important branches of medicine which could be followed at the Institutions specified above, if they were in some way combined with the central Hospitals. The admission also of the students of general Hospitals to the Poor-law Infirmaries would afford a larger number of cases in proportion to the number of students—very necessary in some schools.

Without expressing any view on the question of the practicability of any remedies which may be suggested for these deficiencies, it is felt that they constitute a part of the subject-matter which might be advisably included in the scope of any public inquiry.

The Nursing Department is only second in importance to the Medical. Every Hospital ought not only to provide properly-trained nurses, but also to be a training-school. This, however, would entail considerable cost beyond the means at the disposal of the authorities.

No. 7.—That the operation and constitution of the numerous special Hospitals and Dispensaries demand inquiry, in order to inform the public as to the advantages and disadvantages of such Institutions.

It is submitted that these special Hospitals and Institutions overlap the general Hospitals in many instances, that they actively compete with each other, often misdirect benevolence, and are thus demoralising in their tendency. Moreover, the public possess no trustworthy guide as to their necessity, or *raison d'être;* neither are they acquainted with their character nor with the fact that they are constantly repeating each other, causing thereby great waste of means and material. Absence of combination also engenders extravagance and waste of expenditure, as the various

cases treated in special Hospitals would be better, or as well, tended under one roof. They are, indeed, in a measure private institutions without the advantages attendant upon properly qualified consultative medical authority; and their divergences of practice, both with regard to questions of finance and of medical statistics, produce unreliable data which is calculated to mislead rather than guide the public with respect to their advantages or disadvantages. Students, moreover, are often precluded from making use of these special Hospitals, and consequently they are afforded but slight opportunity of acquiring a knowledge of many important details connected with special disease, and are thus apt to neglect valuable branches of medicine. This would be obviated if these institutions were in some way combined with, or at least placed in relation with, the central Hospitals. It is furthermore pointed out that the cost of administration in 66 special Hospitals differs to the extent of 52 per cent.; in 37 instances the percentage of cost of management to maintenance being over 10 per cent., and in 19 instances over 20 per cent. That this need not be so is evidenced from the fact that in 47 Convalescent Homes, where greater care is exercised in the administration, the cost of management is almost uniform.

No. 8.—That it is desirable that a uniform system should be devised and adopted of keeping the books of accounts and registers of diseases in all Hospitals.

A glance at the published balance-sheets of the various Hospitals will suffice to show the difficulty, if not the impossibility, of instituting comparisons between the relative expenses of each Institution. Before such a comparison per patient can be made, it is necessary to reduce to a common basis the various statements of accounts in order that they may be prepared in an identical manner and under identical heads, each of which shall include identical items. The diversity of systems of Hospital book-keeping, and the unreliableness—because the basis is never identical—of the statements as to cost per patient furnished by Hospital authorities, is shown by a comparison of their figures with those recently worked out on an identical basis by Mr. Burdett, a copy of whose recently published tables accompanies this Memorandum. The adoption of a uniform system of book-keeping should, moreover, be supplemented by the institution at all Hospitals of an audit by a professional accountant, elected annually, and in whose election the subscribers should have a voice. It is, moreover, a matter of public interest to know whether the large sums subscribed for charity of this kind are spent properly, and no other mechanism than that of a Government Commission could ascertain this. Additional confidence in the economical administration of the various Institutions would be thereby in-

spired, whilst at the same time the efficiency of the management would not be impaired, and the support from a benevolent and grateful public would be stimulated.

With regard to the recommendation that a uniform system of keeping the registers of diseases should be adopted, too much stress cannot be laid on the conveniences and advantages that would result to medical science and knowledge if a systematic classification were to be uniformly carried out. Such a classification would be of deep interest and usefulness to sanitary authorities and to the medical officers of all Hospitals.

TABLE

SHOWING

Return of Number of Beds; Average Number of Beds daily occupied; Number of In-Patients and Out-Patients treated at the

METROPOLITAN GENERAL HOSPITALS

during 1880.

	HOSPITAL.	A. Number of Beds.	B. Average Number of Beds occupied daily.	In-Patients.	Out-Patients, Casualties, &c.
	St. Bartholomew's	668	559	6432	172,432
	Guy's	650	506	5189	60,404
	St. Thomas's	572	365	4081	78,742
	St. George's*	351	279	3543	15,095
	Middlesex	310	247	2545	28,329
	King's College*	205	169	1712	14,069
	University College	203	171	2789	22,184
	Westminster	200	154	2003	17,682
	Charing Cross	150	124	1477	19,003
	Royal Free*	150	88	1360	23,812
1.	Total within 1½ miles of Charing Cross.	3,459	2,662	31,131	451,752
2.	In North London (Great Northern)	33	28	350	9,352
	The London	790	550	6,312	55,765
	Metropolitan Free	20	20	275	46,295
	Total in East	810	570	6,587	102,060
	St. Mary's	190	179	2,126	19,313
	West London	42	36	555	22,737
	Total in West London	232	215	2,681	42,050
	Total in London	4,534	3,475	40,749	605,214

* Partially closed for repairs for some portion of the year.

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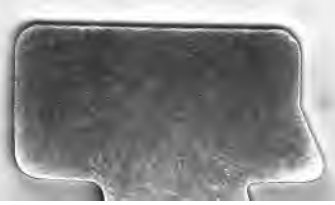


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